DOCUMENT RESUME

ED 164 084 PS 010 113

TITLE	Project Care: Child Advocacy Resources Expansion. Annual Report FY '77.
INSTITUTION	Texas State Dept. of Human Resources, Austin.
SPONS AGENCY	Office of Child Development (DHEW), Washington, D.C.
PUB DATE	[77]
GRANT	OCD-90-C-576
NOTE	157p.
EDRS PRICE	MF-$0.83 HC-$8.69 Plus Postage.
DESCRIPTORS	Annual Reports; *Child Abuse; *Child Advocacy; Child Welfare; *Community Service Programs; Delivery Systems; *Medical Services; Military Service; Objectives; Parent Education; Prevention; Program Descriptions; *Program Development; Program Evaluation; Research; *Social Planning; Social Services
IDENTIFIERS	*Child Advocacy Resources Expansion

ABSTRACT

Project CARE's Second Annual Report identifies and describes activities undertaken by CARE staff between 1 July 1976 and 31 August 1977. Each section addresses a major project component, function, or activity proposed or achieved and contains tasks and accomplishments projected for completion during the third and final year of operation. Section 1 reviews the current status of Project CARE. An assessment of the progress by CARE staff in achieving the original objectives of the project is presented. Section 2 provides a detailed description and analysis of the project's service delivery system and an evaluation of the project's implementation period. Section 3 details the project's preventive/educational efforts. Section 4 outlines the background and development of CARE's Social Policy Study and Section 5 addresses the preliminary findings of the project's Research Study. Section 6 reviews the major conferences and seminars undertaken during the second year. Section 7 describes the project's accomplishments and Section 8 graphically outlines tasks accomplished during the first two years and itemizes tasks projected for the remaining months of the project. Section 9 reviews the methods employed to document and disseminate project information. (Author/RH)

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PROJECT CARE

Child Advocacy Resources Expansion

Funded under grant #90-C-576 Office of Child Development, Department of Health Education and Welfare

Annual Report

FY '77

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PS 010113

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Summary

Project CARE has made significant contributions to military and community service delivery systems in San Antonio during its twenty-six months of operation. The project's activities during its second year focused upon enhancing and refining efforts undertaken within the implementation period. The major obstacle, of maintaining the project's identity as an innovative demonstration project, and yet conforming to the structural and procedural requirements of its host environments, has been overcome. The project has overcome numerous additional systemic constraints, which may serve as a learning tool to others who strive to integrate into any well-established network of resources and providers.

CARE has brought about major achievements in the provision of case-work services, preventive and educational endeavors, and the accomplishment of research and planning activities. It is anticipated that during the third and final year of funding the project can build upon this foundation and leave behind innovative, tested, and effective program components and activities to aid troubled military families.

CARE has identified priorities for its final year of funding and is establishing strategies and safeguards to insure continuation of the project's mission, services, and activities. All activities undertaken during CARE's final year will share a common theme: refinements of concepts previously developed and, ultimately, assumption of responsibility by military and community child advocates.

The project's most valuable contributions may well be the establishment of a viable interface among San Antonio's child advocacy systems and the potential for replication of an exemplary model, capable of prompt intervention and responsiveness with a broad continuum of the services required by troubled military families.

OVERVIEW

Project CARE's Second Annual Report is divided into nine sections identifying and describing activities undertaken by CARE staff between 1 July 1976 and 31 August 1977. Each section addresses a major project component, function, or activity proposed or achieved during the time period covered by the Annual Report. Additionally, each section contains tasks and accomplishments projected for completion during the final months of Project CARE's third and final year of operation. The specific focus and contents of each of CARE's Second Annual Report sections follows.

Section 1 is a review of the current status of Project CARE. An assessment of the progress by CARE staff in achieving the five original objectives of the project is presented. Section 2 provides a detailed description and analysis of the project's service delivery system and an evaluation of the project's implementation period. Section 3 details the project's preventive/educational efforts. The development, negotiation, implementation, and current status of each component are described.

Sections 4 and 5 provide the focus and scope of CARE's research and planning activities. Specifically, section 4 outlines the background and development of CARE's Social Policy Study and section 5 addresses the preliminary findings of the project's Research Study. Section 6 reviews the major conferences and seminars that the project undertook during its second year.

Section 7 describes the project's accomplishments and section 8 graphically outlines tasks accomplished during the first two years and itemizes tasks projected for the remaining months of the project. Section 9 reviews the methods employed to document and disseminate project information.

Section 1

REVIEW OF CURRENT STATUS

Project CARE's second year of operation ended 30 June 1977. During this period the project undertook and completed numerous activities to lay a foundation for the execution of objectives to be accomplished during the third and final year of the project. All tasks scheduled for the project's second year are on schedule. Tasks and objectives scheduled for the project's final year are presently being assessed and refined prior to implementation.

STATUS OF PROJECT OBJECTIVES

Following is a discussion of project objectives as they were originally proposed and have actually been carried out.

Objective One: Demonstrate systematic planning of the project effort by multiple military installations, community agencies, Texas State Department of Public Welfare (DPW), and the project staff. This objective was scheduled for the planning period and included staffing the project, assessing needs and resources, gathering baseline data, and developing strategies for carrying out the project. Planning period staffing was complete by the end of September 1975 and the service staff was on board by 1 February 1976, approximately 1½ months behind the original schedule.

Assessment of needs and resources and the gathering of baseline data were carried out on schedule. Information generated by this aspect of the project will be of interest to all providers of social services to military families, because few such in-depth studies have been carried out up to this time. In retrospect: however, it has become apparent that, while the information collected was extremely important, more time should have been scheduled for studying the dynamics of the child advocacy system and the actual details of service delivery procedures.

Most implementation strategies had been developed by the end of the planning period and detailed plans for the service delivery system were developed during the following two months. By November 1975, it became apparent that not only were the child advocacy services at Brooke Army Medical Center (BAMC) and Wilford Hall Medical Center (WHMC) somewhat fragmented, but that there was no clear definition of services or responsibilities. Neither project nor military staff had anticipated the level of detailed planning required to develop a coordinated system. A vast number of day-to-day details, job descriptions, and professional relationships had to be worked out, one by one, at each hospital. In addition, publication of new Army and Air Force child advocacy regulations substantially changed the legal environment of the project and produced unexpected ambiguities in jurisdiction and responsibilities. At WHMC, in particular, the creation of a child advocacy officer billet produced an organizational change that required additional planning and negotiation. Since organization and structural problems could be fatal to successful replications of this system,

the extra two months of planning were considered a good investment of time and resources.

Objective Two: Integrate and expand a community-wide referral and resources network for maximum utilization of community and military services by troubled military families. Accomplishment of this objective, which will continue throughout the project's three years, is on schedule.

Ongoing conferences with military and civilian protective services staff have been held to clarify role definitions and referral procedures and to facilitate prompt intervention with troubled families. Emergency and intake procedures, phone numbers, and contact persons at WHMC and BAMC have been provided to service delivery staff; and broader dissemination to child care workers, hot line volunteers, and other military and civilian service deliverers is planned. In August 1976, Project CARE assumed total responsibility for the execution of intake and assessment of all military families referred by the WHMC Child Advocacy Officer (CAO). Effective March 1977, CARE assumed primary responsibility for the military referral network at BAMC. CARE's experience with both of these referral systems will be carefully documented, and recommendations will be made to ensure the maximum provision of prompt intervention and minimal duplication of service deliverers' efforts.

A military resources handbook had been printed and widely distributed within the community-at-large, as well as to military users. Educational modules for military referral sources have been implemented, and plans are under way for the delivery of orientation programs to civilian sources. The Third Annual San Antonio Child Abuse Conference was held in June 1976, and Project CARE played a major role in planning, funding, and participating in the conference. The Fourth Annual San Antonio Child Abuse Conference is scheduled for January 1978. CARE assumed the responsibility of planning a military workshop at NCCAN's national conference in Houston last April. Project CARE has received extensive publicity in the San Antonio area, as well as state and national exposure, through its participation in conference workshops and panels. Organizations and individuals on an extensive mailing list are periodically informed of the project's progress through dissemination of project reports. CARE is undertaking the task of scripting and filming a media presentation on the military child advocacy program. This presentation is scheduled for completion during the project's final year.

Objective Three: Expand existing treatment and prevention services available at Wilford Hall USAF Medical Center and Brooke Army Medical Center so that a full range of services is available to troubled military families. A major objective of the project continues to be the expansion of existing treatment and prevention services available at WHMC and BAMC, so that a full range of services is available to troubled military families. Since these two medical complexes serve all Army and Air Force personnel and dependents within the target area, project staff members were assigned to these two units. After the project staff began service delivery it became apparent that Randolph AFB was not prototypical of the major medical installations at BAMC and WHMC and consequently would afford the project an experience more typical of the average military installation, with limited facilities and personnel.

Details of a basic service delivery system were completed in February 1976. Concomitantly, existing services were expanded by assignment of a guidance counselor, a child advocacy coordinator, and two secretaries to BAMC. Early in March 1976, the service delivery staff at WHMC was augmented by the placement of three project social workers and one secretary at that installation. It was not until September 1976 that a project social worker from WHMC was assigned to Randolph AFB on a part-time basis.

Since the initial assignment of the project staff to the service delivery systems a number of significant staff changes have occurred, both within the project and within the host environments. This has necessitated some changes in the focus, quantity, and quality of services provided. These staff changes have also required a shifting of remaining project personnel to new or different assignments and, still continuing, renegotiations with the military installations and local child welfare units for specific assignments of new project personnel.

The two military medical centers already have programs utilizing the multidisciplinary approach to child abuse/neglect (CA/N). However, these services are fragmented and inconsistently utilized. The project's primary approach to this problem is to facilitate the development of a consistent, coordinated approach by all disciplines to child abuse/neglect cases. A multidisciplinary staffing model for identification, assessment, reporting, treatment, and follow-up of CA/N cases was designed. It became apparent that a revised system, involving all disciplines, could not be superimposed, in totality, upon the existing system. The social work role was then selected as the focal point of clarification and innovation in the areas of intake and assessment.

The introduction of military regulations establishing the Army and Air Force child advocacy programs demanded a more formalized approach to the problem of child abuse and neglect. These official mandates highlighted the need for clarification and delineation of the roles, responsibilities, and functions of all the disciplines represented on the committees or councils. Since these official bodies are composed both of disciplines responsible for the direct services to families and disciplines providing collateral and legal support, much remains to be done in crystalizing and solidifying the functions of the membership.

Strict adherence to the Privacy Act of 1974 presented some impediments to the necessary exchange of information. This especially impacted upon project personnel and representatives from Bexar County Child Welfare (BCCW). This impediment was removed by publication of systems notices in the Federal Register that established project personnel and BCCW representatives as "routine users." A rudimentary system for the exchange of information among disciplines now exists. The difficult task of transforming that system into a viable treatment team lies ahead.

A vast number of day-to-day details of professional responsibilities, role definition, and departmental and agency interface have had to be worked out, one by one, at each installation. Since the resolution of organizational and structural problems will be vital to the successful replication of this system, meticulous negotiation of interface is impera-

tive. Details of organizational planning are being carefully documented and may eventually result in a blueprint for military installations that implement similar child advocacy programs.

The total system developed during CARE's first twenty-six months differs only slightly from the system envisioned in the original proposal, although--in response to the project's needs assessments, changing legal environments, and systemic constraints--emphasis has shifted to a broader model stressing prevention and early intervention. Additionally--in keeping with the broad objectives of Army and Air Force child advocacy regulations--the project has developed, negotiated, and implemented programs of professional and community education in child abuse prevention, parenting education, and substitute child care. Programs have been coordinated to ensure that a wide range of professionals, military families, and the community-at-large have been exposed to elements of an extensive network of programs for prevention of child abuse/neglect and the promotion of family advocacy. To facilitate continuity of these programs beyond the project's remaining year; additional existing service deliverers are being identified and a curriculum manual, chronicling the project's experiences, is being developed.

Objective Four: Develop and pilot test an innovative staffing model for the State Department of Public Welfare protective services casework for military populations. During the project's first year the DPW regional administrator agreed to assign a DPW worker to BAMC immediately. Implementation had been scheduled for May 1976; however, interpretations of the Federal Privacy Act raised a number of issues regarding the relationships of military installations and local welfare agencies. Although these issues were resolved by the issuance of Army and Air Force systems notices late last year, it has been decided to delay placement until the last year of the project. This extension of time will allow CARE to refine the project's social work service model and facilitate the integration of DPW protective service staff into the existing military service delivery environment.

Objective Five: Perform a policy study on the Bexar County military community's response to the problem of child abuse and neglect, based on the social policy model developed by Gil (1973). Accomplishment of this objective has been scheduled for the third project year, and extensive background material has been collected to date. Problems in service implementation, as well as the project's experiences in working within established policies and participating in the implementation of new policies, have been incorporated into the theoretical foundation of this study. The scope, process, and research design of the study are presently being conceptualized.

During the second project year, research was initiated to identify characteristics of military families reported to civilian and military child protection programs in San Antonio, Bexar County, and the surrounding four counties. The study will describe military and civilian service delivery system responses to child abuse cases and identify case management issues specific to military-civilian cooperation in child protection efforts. The study was initiated 1 October 1976 and data collection con-

tinued through June 1977. The preliminary findings of the study were presented at the Military Family Research Conference held in San Diego in August 1977. Finalization and distribution of the study are scheduled for November 1977.

Section 2

SERVICE DELIVERY SYSTEM

INTRODUCTION

The primary goal of Project CARE is to demonstrate the effectiveness of community-Army-Air Force-Welfare Department planning in providing military families with a broad spectrum of services for prevention, diagnosis, and treatment of child abuse and neglect. Concommitant with this goal is a commitment to the promotion of child advocacy and the enhancement of life of military families.

A major objective of the project is to expand existing treatment and prevention services available at Wilford Hall Medical Center (WHMC) and Brooke Army Medical Center (BAMC) so that a full range of services is available to military families within the target population. The project's primary approach toward achievement of its goal is to facilitate the development of a consistent, coordinated approach by all disciplines to child abuse/neglect and child advocacy cases. A multidisciplinary staffing model has been designed for the identification, assessment, reporting, treatment, and follow-up of child abuse/neglect cases and constitutes a comprehensive service delivery system. Details of this service delivery system were completed in February 1976 and have been incorporated into a Social Work Procedures Manual. It became apparent during early negotiations that a total revision of the existing system could not be imposed upon all disciplines simultaneously, therefore, the social work role was selected as the focal point in establishing the multidisciplinary approach.

The processes inherent within the implementation of the procedures are intended to enhance communication among disciplines, and to clarify roles and responsibilities. Adherence to the procedures also facilitates a comprehensive assessment of medical, social, psychological, and environmental stress factors which may contribute to abusive or neglectful patterns within families. The service delivery system also provides for consistent collection and recording of case data, on forms specifically designed to elicit data pertinent to abuse or neglect situations.

AN OVERVIEW OF SYSTEMS

One of the more challenging tasks of Project CARE has been the planning, coordination, and implementation of multidisciplinary services to military families within an extremely complex environment. The three integral components of the Project--Army, Air Force, and the Texas State Department of Public Welfare (DPW)--are all well-established bureaucracies with individualized systemic constraints. CARE interface within each bureaucracy, regarding organization and delegation of basic responsibilities, has been an enormously time-consuming activity and, invariably, established departmental priorities, policies, and procedures pre-empted the newly-acquired child advocacy commitments of the military services. Mandatory adherence to established missions necessitated assumption of child advocacy

responsibilities by existing personnel, rather than by allocation of additional staff.

After departmental allocations of personnel and available resources were made there remained the problem of coordinating the services of a variety of departments into operational multidisciplinary procedures. In addition to these inherent constraints, legal impediments of the Privacy Act of 1974 (since resolved) restricted the sharing of the client information that is so vital to a multidisciplinary or interagency approach to child advocacy services.

The constraints encountered in the coordination of a multidisciplinary service delivery system were bureaucratic, organizational, operational, and legal. The negotiations required to implement services have been continuous, meticulous, and individuated within each system. The broad systemic constraints of each component: Army, Air Force, and Department of Public Welfare will be identified and discussed within this section.

Perhaps one of the greatest hindrances in merging separate bureaucracies into a functioning team is the presence of parallel suprastructures of administrative regulations and procedures. There are areas in which change is negotiable; but in other, equally vital, areas policy is fixed and any deviation requires the formal permission of an entire chain of command. In order to understand the complexity of negotiating three bureaucracies toward the achievement of a shared goal it seems appropriate to consider the definition of a "bureaucracy." Webster's Collegiate Dictionary provides two definitions, which seems most reflective of the project's experience. The definitions are as follows: "a system characterized by specialization of functions, adherence to fixed rules, and a hierarchy of authority; a system of administration marked by officialism, red tape, and proliferation."

If negotiations with a bureaucracy are to be successful it is imperative to be totally familiar with the chain of command and all of its component parts. This depth of knowledge is difficult for one outside of the system to acquire. Without this knowledge, and a concommitant awareness of the protocol required in addressing the system, an effective impact is impossible.

A successful multidisciplinary system of services is dependent upon several basic factors: administrative support, acceptance of a basic philosophy, a common goal, clarification of functions, clinical maturity on the part of the participants, and a structured integrative process. In dealing with an authoratarian bureaucracy, such as the military, the most important of these factors is upper echelon administrative support and its frequent reaffirmation by administrators to subordinates.

Essentailly, Project CARE has been negotiating with two differently constructed military abuse programs. Although both the Army and the Air Force child advocacy military regulations have a common goal the structures of the programs is considerably different. The Air Force program is primarily hospital based; emphasizing the medical model in identification, treatment, and follow-up of child abuse cases. The Army program is

community-based and incorporates additional disciplines, other than those normally assigned to hospitals. Consequently, negotiations within a hospital are infinitely less complicated than negotiations within a wider community complex.

In both the Army and the Air Force, the medical model has been the pattern for early development of child abuse programs. In military, as in civilian models, it has been the pediatrician who has spearheaded the concern for children with unexplained injuries. While the identification of physical child abuse and neglect is primarily a medical function the protection of the child and the remediation of the causative factors are rooted in social work practice. Social workers have traditionally assumed the role of coordinator in most hospital multidisciplinary teams and social work agencies are legally mandated to provide protective services and alternate care to children. It follows; then, that the nucleus of all child abuse/neglect programs, or treatment teams, should be composed of the pediatrician, the clinical social worker, and the child protective social worker. Child abuse teams, as they evolved within the military prior to command regulations, usually were initiated within hospital settings with pediatricians, medical social workers, and protective social workers as the primary facilitators. Out of this early evolutionary processes has grown an awareness of the need to involve other professionals to fully address the complex problem of child abuse. This need is recognized by the variety of specialists delegated membership on child protective councils by both Army and Air Force regulations.

While there are many similarities in the disciplines represented on the Army and Air Force child protective councils, there are also differences. The differences may be explained in part by the professional specialties available within each military branch of service. There are also differences which are related to the composition of the two military regulations, since each specifically designates the membership of the councils. Additional differences stem from the scope of a hospital-based program compared to a community-based program.

Army

By regulation the Army Child Advocacy Program (ACAP) has four main objectives. These objectives are:

- Develop a community based program to monitor and coordinate all programs and services that impact on children's growth and development
- Identify, use, and strengthen existing community resources to enhance the general welfare of children
- Prevent and control child maltreatment by educating and training in the recognition of the causes and consequences of child maltreatment to all personnel; particularly those personnel in the command who provide health and welfare services to military families

- Identify, report, and manage cases of child maltreatment among military families

These four objectives are to be accomplished through the establishment of two organized efforts, the Army Child Advocacy Program and the Child Protection and Case Management Team (CPCMT). The Army Child Advocacy Program is a generic program that has at its disposal all of the resources available through the Human Resources Development Council. The Army Child Advocacy Program is a general personnel regulation, with casemanagement responsibilities actually assigned to a multidisciplinary team. The CPCMT is a specific organization composed of service delivery personnel and its purpose is to identify and manage child abuse/neglect cases.

The Army regulation directs that the CPCMT will consist of pediatricians, psychiatrists, psychologists, social workers, nurses, and lawyers. At the discretion of the medical treatment facility commander other personnel, who may contribute to the evaluation and treatment process, may be included in the membership. Law enforcement personnel, civilian child protection workers, and chaplains are suggested as potential members.

The Army Child Advocacy Program is a command program. This means it is the ultimate responsibility of the post commander. However, the responsibility for supervising the CPCMT is assigned to the medical treatment facility commander. The Fort Sam Houston Army child advocacy officer is assigned by the post commander, while BAMC personnel perform patient services, this constrains his functioning. A better model may be to delegate ACAP officer responsibilities, along with the CPCMT responsibilities, to the medical services component. This would place the ACAP officer within the service delivery system and would give greater credibility to his role as a participant in policymaking decisions of the CPCMT.

Although the Army regulation provides for a multidisciplinary approach to child abuse and neglect cases, and suggests the composition of membership to the CPCMT, it does not provide guidelines for interface or define the respective responsibilities of this diverse assemblage of professionals. It is doubtful that any regulation could define responsibilities that specifically; however, if the program is to be effective specifics of roles and functions in casemanagement must be addressed.

The most logical way to clarify roles and responsibilities would be to develop departmental procedures for responses to child abuse and neglect cases, and to formulate these various departmental procedures into a general protocol for medical and non-medical management of cases within the hospital setting. Each Army post would need to construct its own child abuse/neglect protocol, in conformity with the personnel resources available.

All of the professional representatives suggested by the regulation for membership in the CPCMT are available at BAMC. Most members of the CPCMT are responsible for direct delivery of services to clients; however, all members are seldom involved in every case. In fact, most disciplines provide services on a consult basis, depending on the case situation. For

example, the psychiatrist, psychologist or Army community health nurse are best utilized in cases requiring their specific skills and services. Whereas the physician, the hospital social worker, the county protective services worker, and the clinic or ward nurse would be involved in almost every case.

Under the present system at BAMC, there are at least nine disciplines or departments represented at each CPCMT meeting. The primary discussion of cases is appropriately between the pediatrician, the medical social worker, and the county protective services worker. Other disciplines participate as advisors or offer professional opinions about aspects of the case. While the expertise of all CPCMT members is necessary and valuable, there are better ways to utilize their professional time. It has been suggested that total membership of the CPCMT not meet weekly as a treatment team, but that they meet monthly as a professional review board to monitor all active child abuse and neglect cases. It has been further suggested that the treatment team consisting of those disciplines providing services to all cases, such as pediatricians, social workers, nurses, and protective services workers meet weekly to staff cases to be presented to the CPCMT. This would facilitate the assessment and treatment processes and would provide for better utilization of all professionals' time.

As a result of CARE's input, a directive by the BAMC commander has established a task force to plan a viable multidisciplinary approach to child abuse and neglect. The efforts of the task force should result in the resolution of many existing constraints.

Prior to the issuance of this directive Project CARE had been enmeshed for months in negotiations with several service delivery departments. The complexity of this negotiation process has already been described. It will be interesting to compare the results of the command mandated task forces efforts with the project's efforts, accomplished without the benefit of a directive from the commander.

Air Force

The Air Force Child Advocacy Program regulation is a medical service regulation, which assigns responsibility and explains policy and procedures for the medical and nonmedical management of child abuse or neglect cases. The purpose of the program is "to prevent child abuse and neglect and their attendant problems and to identify, treat, and rehabilitate the abuser/neglector as well as to treat the abused child." The program is organized to coordinate available civilian and military resources and to facilitate the actions of medical personnel and other concerned individuals.

The installations Child Advocacy Committee (CAC) is to be composed of the Director of Base Medical Services (DBMS) or the Chief of Hospital Services, the Children Have a Potential (CHAP) and Child Advocacy Officer (CAO), and representatives of the Staff Judge Advocate, Director of Personnel, Chief of Security Police, Chaplain, and Special services officer.

It is obvious that the Child Advocacy Committee, as prescribed by the regulation, is composed of administrative rather than clinical personnel. In fact, the only clinical representatives on the committee are the DBMS, usually a physician, and the CAO, usually a social worker. The regulation sets forth HQ USAF responsibility, major command responsibility, and installation responsibility, but does not specifically address child abuse case management as a team or multidisciplinary responsibility. The regulation does endow the CAO with rather broad administrative powers in the areas of case management, education, and coordinaton of community resources.

The regulation provides for the designation of a clinical social worker, when available, as the CHAP and CAO. His considerable duties and responsibilities are specifically spelled out in the regulation. The CAO is directly responsible to the DBMS or the Chief of Hospital Services and is charged with, among other things, the coordination of services, maintenance of the child advocacy case files, and responsibility for completing and forwarding AF Form 120. While the regulation assigns considerable responsibility to the CAO it allows the autonomy necessary to carry out those responsibilities, which has been capitalized upon by the present CAO at WHMC.

In addition to the Air Force regulation, a medical center supplement was drafted for Wilford Hall Medical Center (WHMC) and distributed on 9 April 1976. The supplement assigns the Director of Hospital Services as chairman of the Lackland Air Force Base (LAFB) Child Advocacy Committee. It also established a Child Protection Committee, which is case management-oriented and composed primarily of service delivery personnel. The protection committee membership consists of the CAO, and representatives from the departments of pediatrics, mental health, medicine, neurosurgery, orthopedics, emergency services, and forensic medicine. The committee is co-chaired by the chairman of the pediatrics ward and clinic. The supplement also stipulates interface with Bexar County Child Welfare (BCCW) under appropriate circumstances.

After many months of meeting and negotiations between representatives from the WHMC child protection committee, BCCW, and Project CARE a procedures manual was developed. The manual is in the form of a series of policy letters and attachments dealing with the interface between the military and civilian child advocacy service delivery systems. The contents of the manual are as follows:

1. Case Manager
2. Exchanging Information
3. The Role of the Chairperson of the Child Protection Committee
4. The Role of the Psychiatric Consultant
5. The Role of Project CARE
6. The Role of the Child Advocacy Officer
7. Intake and Assessment Procedures
8. The Role of the Child Advocacy Committee (CAC)
9. The Role of Bexar County Child Welfare (BCCW)
10. The Child Advocacy Card File
11. The Role of the Child Protection Committee (CPC)
12. The Format for Case Presentation Before the CPC
13. The Statement for Parents Entering the Child Advocacy Program

Policy Letters

14. Contractual Treatment Agreements
15. BCCW's Access to Lackland Air Force Base
16. Phone Numbers of Military Child Advocacy Personnel
17. The Liaison with Base Security Police
18. WHMC's Supplement to AFR 160-38
19. Child Advocacy Case Flow Sheet

Advocacy Program

The manual was accomplished through the initiative of the CAO at WHMC. It was co-signed by the chairman of the CPC, the Director of Project CARE and Director of Social Services, region IX, Texas State Department of Public Welfare.

To our knowledge, this manual represents the only comprehensive approach to coordination of services between military and community resources since the inauguration of military child advocacy programs.

Bexar County Child Welfare

Prior to enactment of Army and Air Force regulations establishing child advocacy programs both BAMC and WHMC had committees to deal with child abuse and neglect cases. Both commands had invited BCCW representatives to sit on their committees and to participate in case management decisions. The enactment of the military regulations raised questions regarding the Privacy Act of 1974, and the possible violation of the privacy of patients by sharing information outside of the military system. These questions have since been resolved, and formal negotiations between BCCW and local Army and Air Force child protective committees have been accomplished. These negotiations have resulted in representatives from BCCW and other child welfare units being considered as bonafide members of the child protective committees.

The social services components of the State Department of Public Welfare most directly involved in child abuse/neglect in the San Antonio area are the Bexar County child welfare units, providing intake and investigatory visits; and the Department of Public Welfare protective services units, providing on-going services to families.

The child welfare units are housed and equipped by Bexar County, while the State Department of Public Welfare provides their personnel. Presently there are four intake units in operation. The six on-going protective services units are funded totally by the State Department of Public Welfare.

In addition, there are five supportive units in protective services. These units are: foster home development, foster home certification, permanent planning, adoption, and the night unit.

The primary functions of these units are: to receive and investigate reports of abuse and neglect, to evaluate reported families, and to intervene in the family situations by the provision of direct services or by referral to other community agencies. The child protection agency has the additional obligation to utilize law enforcement agencies and the courts to insure the protection and welfare of children when parents are unwilling to accept help.

"Child protective agencies follow a fairly standard procedure in handling reports. There is an initial intake process that involves limited screening, referral, and case assignment within the agency. The intake worker tries to obtain information concerning the suspected maltreatment in as clear, concise, and concrete a form as possible. The

worker may contact schools, neighbors, relatives, and police to obtain information about the family; and will often check for prior reports involving the parents, child, or siblings" (Child Abuse and Neglect, the Problem and its Management, Vol. I).

During protective services intake the worker is frequently confronted with difficult decisions, often on the basis of limited information. One of the more common decisions is to determine if the child is at risk, and if emergency actions should be taken to obtain temporary protective custody. If temporary custody is required the worker must have a placement plan available. In addition, the worker is expected to plan for the involvement of resistive or unmotivated parents in an involuntary process. "Frequently, the parents view the worker as an intruder into their lives. To be an effective source of help, the worker must establish a relationship of trust with the family. Yet, because the worker is also responsible for investigating the family, the parents have reason to see his or her presence as a threat. Placed in the contradictory position of having to investigate a family while, at the same time, trying to establish a treatment relationship, they must be both policemen and social workers, investigators and friends. Protective services often suffer when workers cannot resolve these basic role ambivalences" (Child Abuse and Neglect, the Problem and Its Management, Vol. I).

Although child protective services in all states follow similar procedures, there is no uniformity among state laws with respect to reporting child abuse/neglect cases. In Texas, the child welfare unit is charged with the responsibility for receiving and investigating all cases of children who are suspected of being abused or neglected. The Texas Family Code, which became effective on 1 January 1974, is very specific as to who is granted authority to remove a child deemed to be in a dangerous situation. It states:

> Section 17.01. Taking Possession in Emergency. An authorized representative of the State Department of Public Welfare, a law-enforcement officer, or a juvenile probation officer may take possession of a child to protect him from an immediate danger to his health or physical safety and deliver him to any court having jurisdiction of suits under this subtitle, whether or not the court has continuing jurisdiction under Section 11.05 of this code. The child shall be delivered immediately to the court.

The county child welfare unit, or the county agency responsible for the protection of juveniles, is given responsibility for making "a thorough investigation promptly after receiving either the oral or written report" (Section 34.05). However, for a civilian agency to enter a military reservation for such a purpose authorization must be obtained from the installation commander.

BCCW was authorized to enter Lackland Air Force Base and Fort Sam Houston prior to Air Force Regulation 160-38. The regulation added legitimacy to investigations of child abuse/neglect cases on military installations by BCCW.

Air Force Regulation 160-38, 25 April 1975, Air Force Child Advocacy Program, states that the installation commander will:

> Cooperate and coordinate with local social service and welfare authorities who have responsibility for monitoring similar civilian programs.

The director of base medical services has the responsibility (para 8A (1) to:

> Establish a procedure for liaison and referral with appropriate local military and civilian health and welfare agencies capable of helping the abuser or neglector.

Resolution of the "Privacy Act dilemma" at BAMC has required reintroduction of the requirement for the written permission of the post commander for BCCW to function in an investigatory capacity.

Entry into the military setting by BCCW has been the result of lengthy negotiations between agency representatives and the military. The concept of a community agency entering a federal installation for investigative purposes necessitated addressing the idea of "territoriality." The military has traditionally functioned in an all-encompassing role toward its servicemen. Its attempts to handle all awkward problems are sometimes not suitable--as in the case of child abuse/neglect. The military has acknowledged this, by acceptance of Project CARE on its installations and by allowing BCCW a more active role in investigating child abuse/neglect situations.

SYSTEMIC CONSTRAINTS

Child abuse and neglect is recognized as a complex psychosocial, as well as a medical problem and the consensus of opinion among professionals is that no individual discipline is prepared to cope with all facets of the problem. General awareness of the complexity of the problem has given impetus to the multidisicplinary, or team, approach to prevention, identification, and remediation of child abuse and neglect cases. The multidisciplinary and team approaches have become synonymous in the minds of most professionals. In fact they are very different concepts. It is possible to have several disciplines providing specialized services to the same family individually without coordinating those services into a team effort. A team approach has, implicit within it, a specific methodology; with basic tenents and techniques utilized by several professionals toward the achievement of a common goal.

A multidisciplinary approach cannot be easily initiated simply because all of the desired professions are readily available, especially if those disciplines exist within bureaucratic systems. Consequently, it was decided to detail Project CARE's experiences at Brooke Army Medical Center (BAMC) in negotiating multidisciplinary agreements within a military hospital setting, for an approach to the child abuse problem. An attempt

has been made to capture the complexity of the negotiations by describing environmental, organizational, operational, and legal constraints factors.

In structuring and implementing components of the service delivery system it has been necessary to negotiate with the departments providing direct services to patients. Negotiations were first initiated with the Department of Social Work Services, since Project CARE's social workers function under the auspices of that department. It also seemed logical that social workers should assume the primary responsibility for the non-medical evaluation of child abuse and neglect cases. Social workers are also assigned to other key departments such as pediatrics, psychiatry, the adolescent medicine clinic, and the USA Institute of Surgical Research (Burn Ward) (See figure 2.1). Since the Chief of Social Work Services is also the military coordinator for the project, it was anticipated that social work services would facilitate liaison with other departments.

Concurrently, the project was establishing direct informal negotiations with the departments of Pediatrics, Army Community Health Nursing, and Bexar County Child Welfare (BCCW) through regular attendance at the Child Protective Case Management Team (CPCMT).

Numerous attempts to formalize interface with these services faltered for a variety of reasons. For example, the Army Community Health Nurses (ACHN) are under the Department of Health and Environmental Service (see figure 2.2), and have a multitude of functions and responsibilities. During the project's tenure, ACHN has had three chiefs of service and the staff has been reduced considerably, affecting their commitment to the program.

Negotiations with the Department of Pyschiatry were never formalized. The department's representatives to the CPCMT has usually been the Child and Adolescent Guidance Clinic Chief, who has interpreted their role as consultant or case manager in cases where psychiatric or psychological services to children or adolescents were indicated. The department has made no commitment to the project for services to adult patients; where their participation is extremely desirable in view of the services they offer to special categories of patients (see figure 2.3), many of whom are involved in child abuse and neglect.

Negotiations with the Pediatrics Department have been both formal and informal. The Community Pediatrician was chairman of the CPCMT, and was personally involved in the medical evaluation of subject children. However, during his absence the continuity of meetings and services to patients was frequently interrupted, in spite of attempts to provide "back-up" for his position. Other staff pediatricians are usually assigned to equally demanding pediatric specialties, consequently the assumption of child abuse/neglect responsibilities often conflicts with previously established commitments (see figure 2.4).

Since its inception, the project has naviely assumed that command administrative support and the coordination of service delivery personnel would insure its success. This assumption was reinforced by the relative

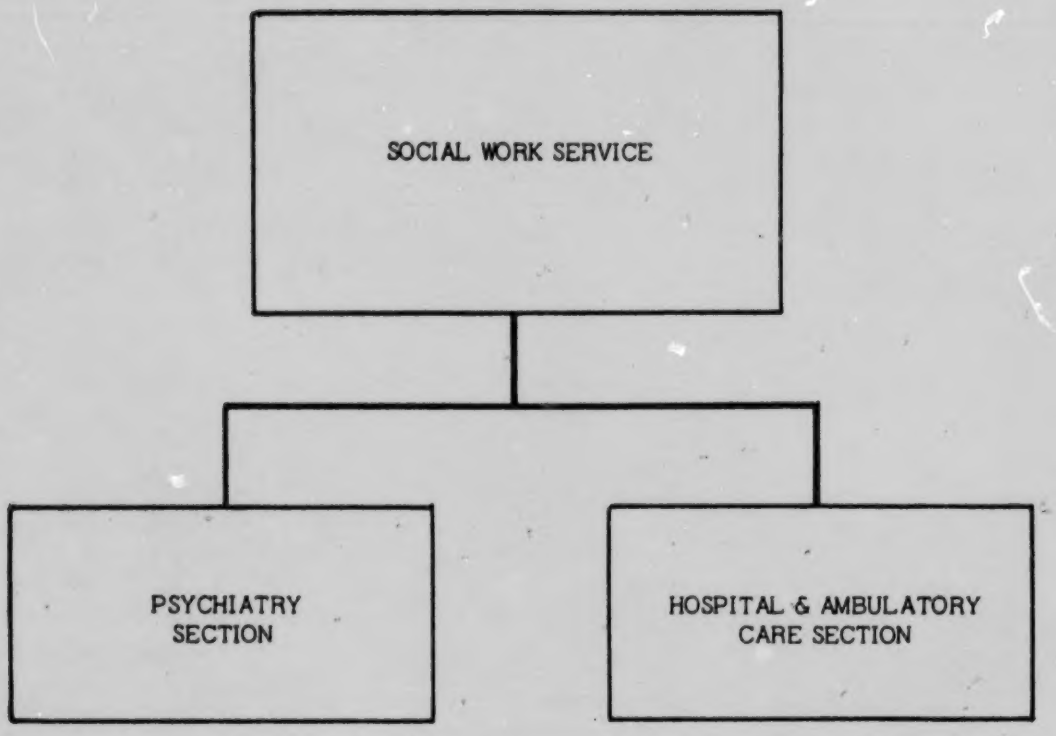
SOCIAL WORK SERVICE
PSYCHIATRY SECTION
HOSPITAL & AMBULATORY CARE SECTION

Figure 2.1

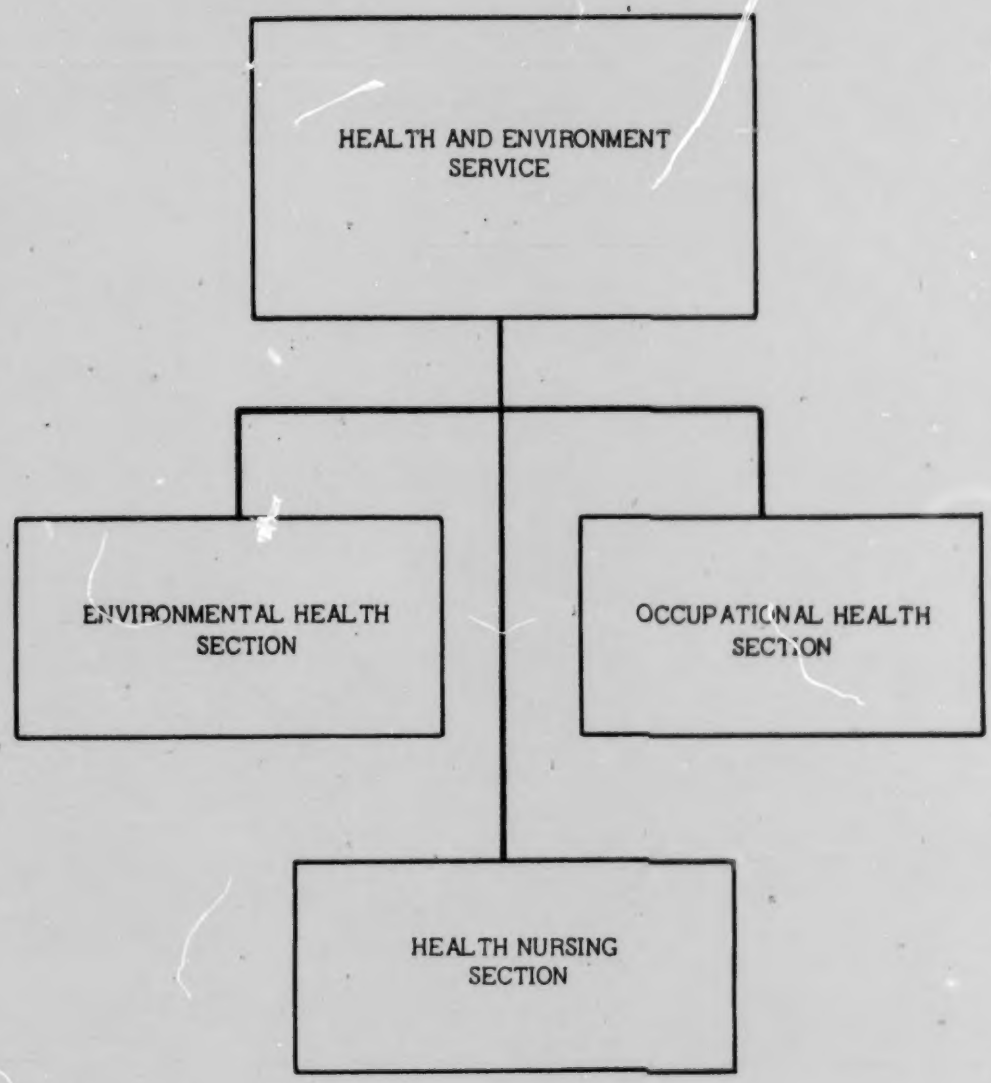
HEALTH AND ENVIRONMENT SERVICE
ENVIRONMENTAL HEALTH SECTION
OCCUPATIONAL HEALTH SECTION
HEALTH NURSING SECTION

Figure 2.2

DEPARTMENT OF PSYCHIATRY

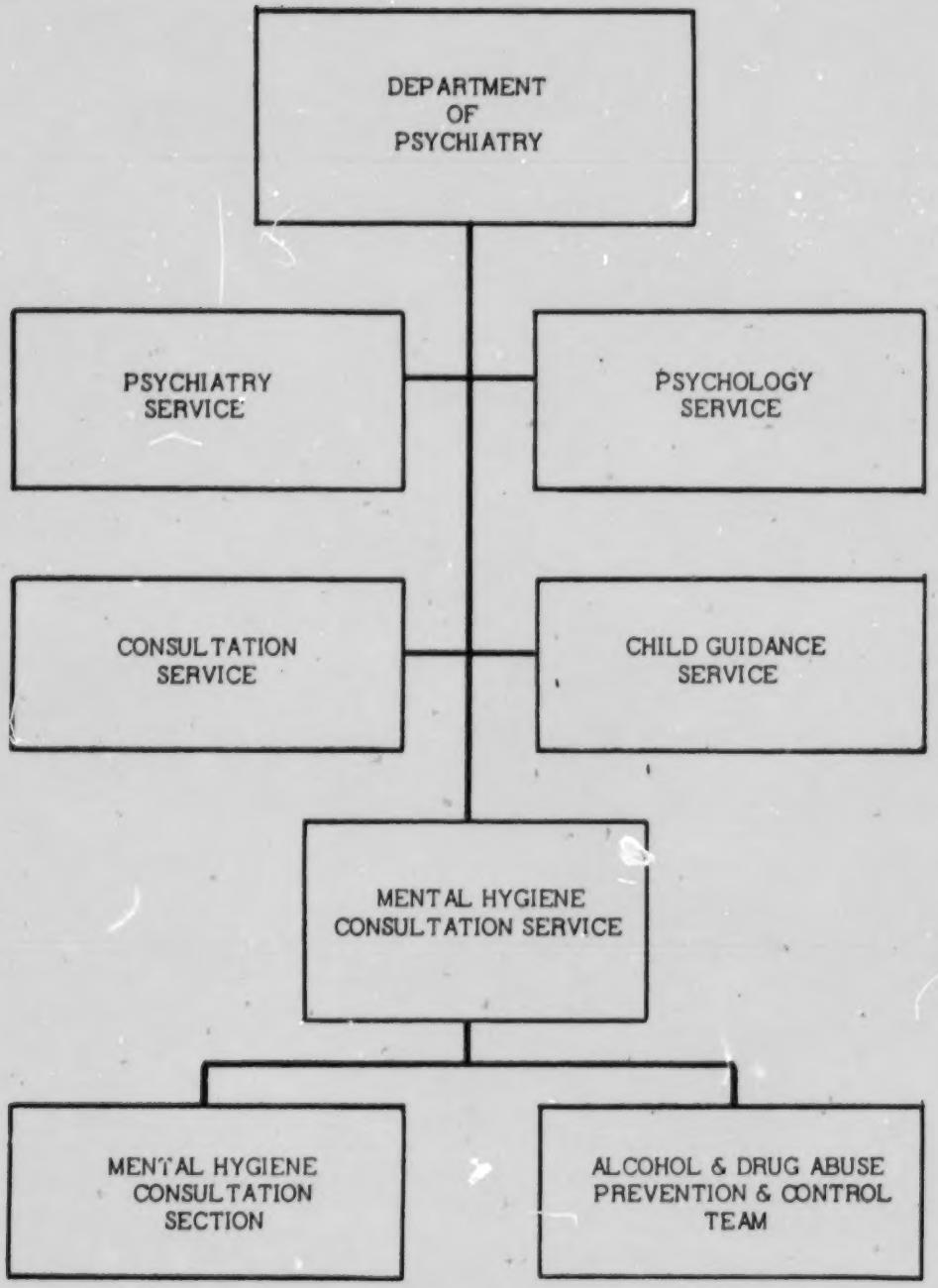

Figure 2.3

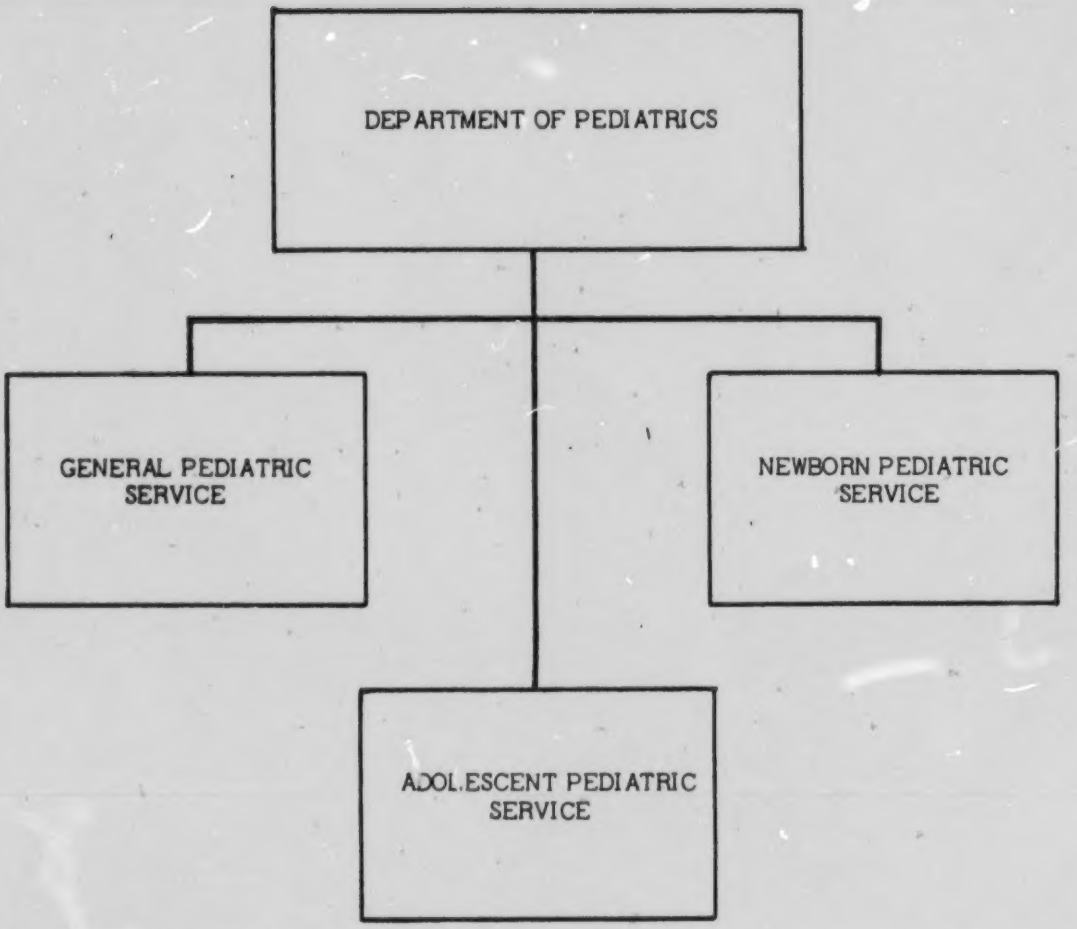
DEPARTMENT OF PEDIATRICS
GENERAL PEDIATRIC SERVICE
NEWBORN PEDIATRIC SERVICE
ADOLESCENT PEDIATRIC SERVICE

Figure 2 4

ease with which project personnel were allowed to demonstrate the social work model. However, when the focus shifted to the ultimate assumption of responsibility for various service delivery components by the military, the need for multilevel negotiation and commitment became apparent.

In many instances decisions imperative to the coordination of disciplines in providing direct services could not be made by line or mid-level personnel. Decisions required the sanction of upper echelon administration, often of more than one system. The inordinate account of time required by departmental decision-making stalemated the coordination of the various components into a multidisciplinary service delivery system.

The problem of viable interface were further complicated by the bureaucratic protocol demanded in both vertical and horizontal negotiations. Because of the complexity of the service components it was not only necessary to negotiate at several strata within a specific department, but it was essential to negotiate horizontially with several levels of supportive administrative components of that department. As an example, at BAMC, the project social workers were given permission to function under the auspices of social work services by the chief of that service. However, he had to submit their credentials to Hospital Administration Division before patients' medical records would be made available to them. The Chief of Pediatrics had to sanction their participation on ward rounds and other ward activities. Interaction with the charge nurses on the ward and in the clinics in the diagnositc and treatment process required permission of the Chief of Nursing Services. In addition to these formal negotiations, the project social workers themselves had to negotiate and clarify their own roles with other service deliverers within the environment.

Concommitant with the ongoing negotiations for allocation of human resources were negotiations to acquire tangible support. For example, three basic forms were designed by the project for use with CA/N and child advocacy cases. These forms required approval by Patient Administration Division and forms management (see figure 2.6 and 2.7) before they could be printed for temporary use. The print shop then required a work order from Social Work Services and written approval by the Patient Administration Division. All these negotiations were necessary before a project social worker could implement the intake and assessment process, the most elementary process of service delivery. If such complex negotiations are necessary to accomplish so simple a task, one can extrapolate how complicated multidisciplinary processes can become.

The bureaucratic and departmental structure of the major systems alone presents sufficient impediments to a viable staffing model. However, there are various personnel constraints which permeate all of the systems and their departments. The first obvious constraint to a multidisciplinary approach is the variety of personnel, under multiple administrative control, functioning without any unified approach or accountability. This impacts upon the coordination of supportive components, such as centralized housing, secretarial services, telephonic capabilities,

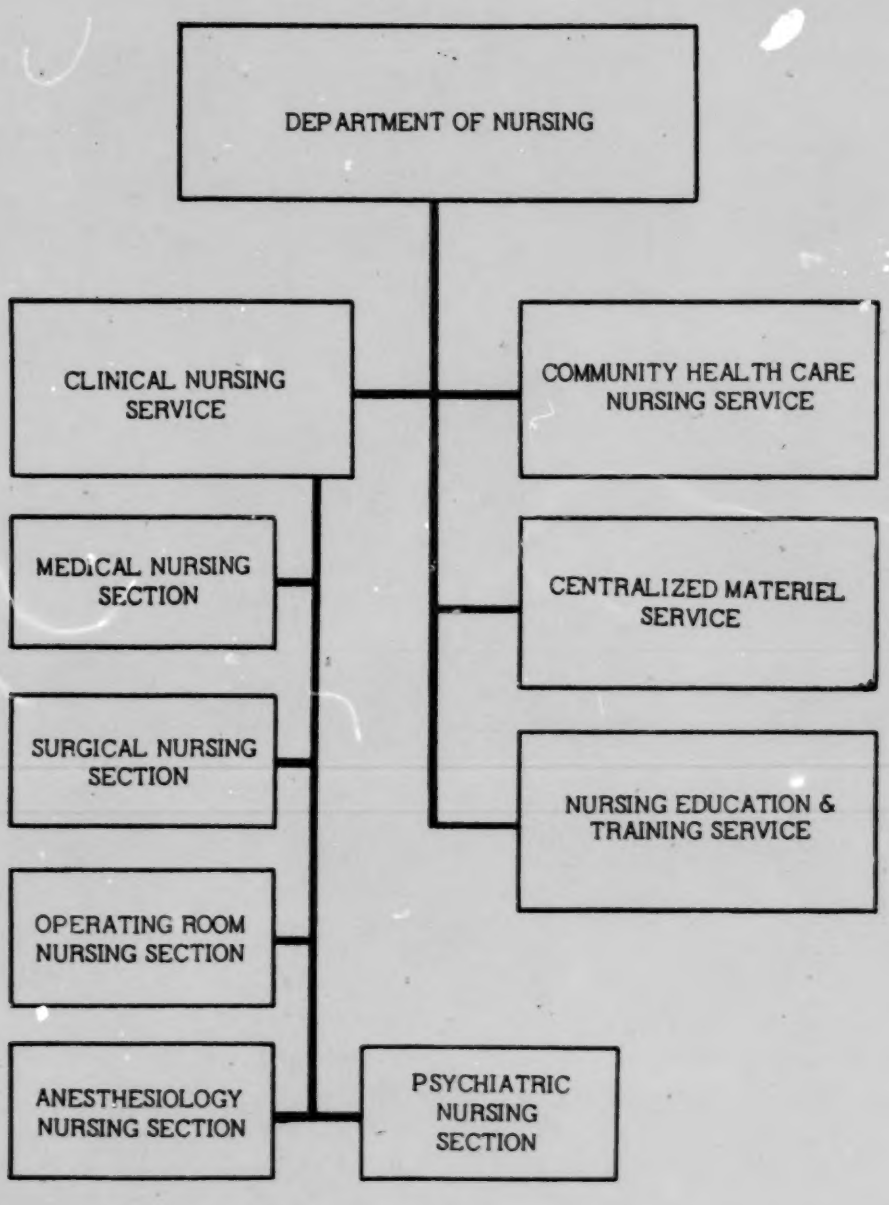
DEPARTMENT OF NURSING
CLINICAL NURSING SERVICE
COMMUNITY HEALTH CARE NURSING SERVICE
MEDICAL NURSING SECTION
CENTRALIZED MATERIEL SERVICE
SURGICAL NURSING SECTION
NURSING EDUCATION & TRAINING SERVICE
OPERATING ROOM NURSING SECTION
ANESTHESIOLOGY NURSING SECTION
PSYCHIATRIC NURSING SECTION

Figure 2.5

PATIENT ADMINISTRATION DIVISION

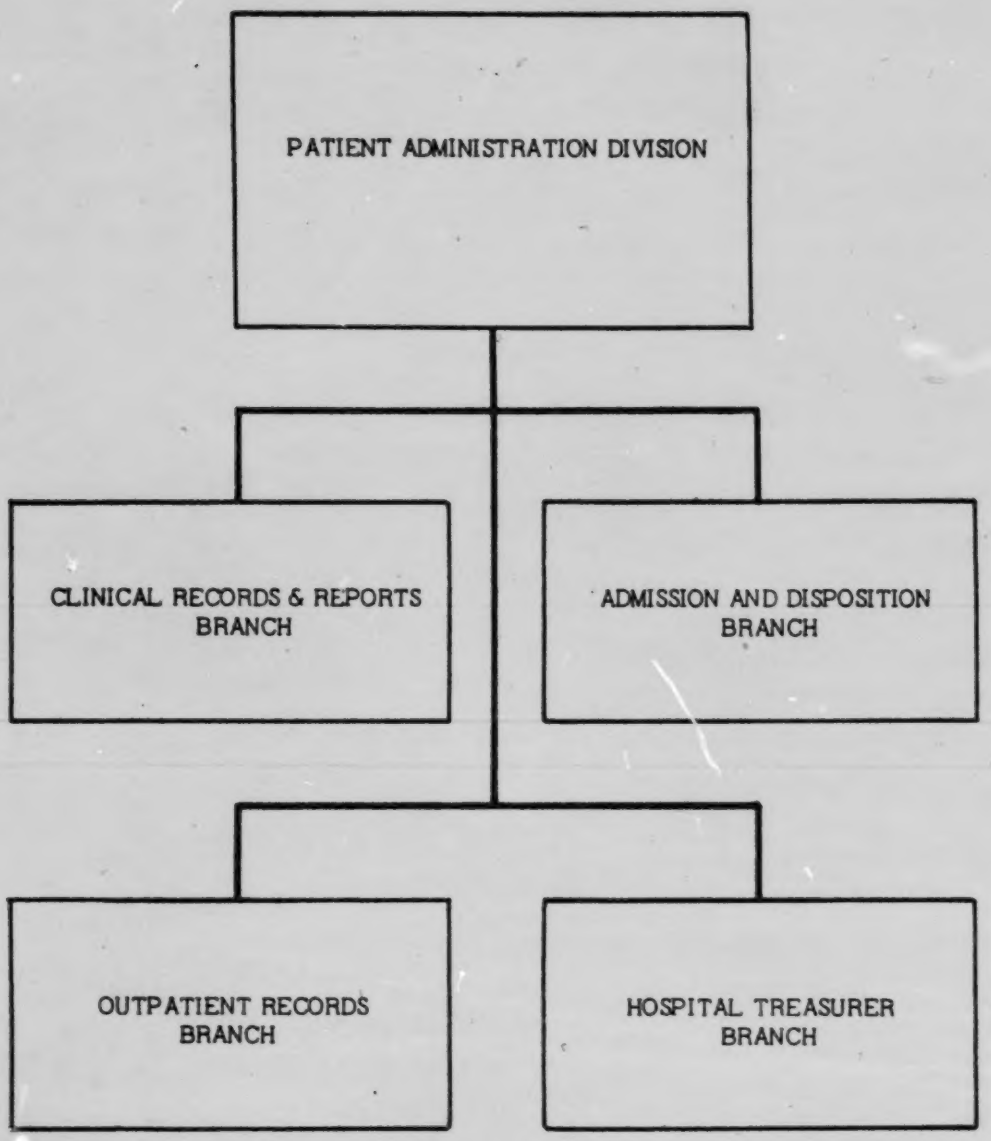

Figure 2.6

OFFICE OF THE ADJUTANT

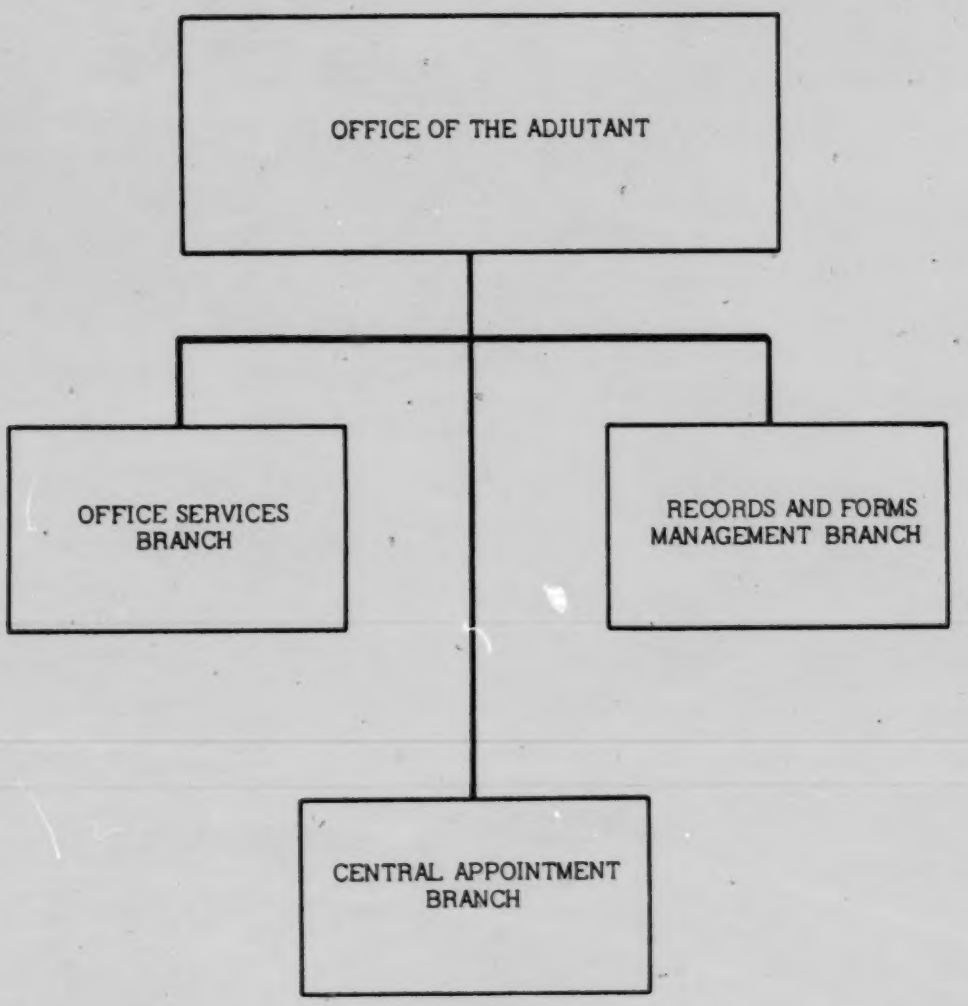

Figure 2.7

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ORGANIZATIONAL CHART, BROOKE ARMY MEDICAL CENTER

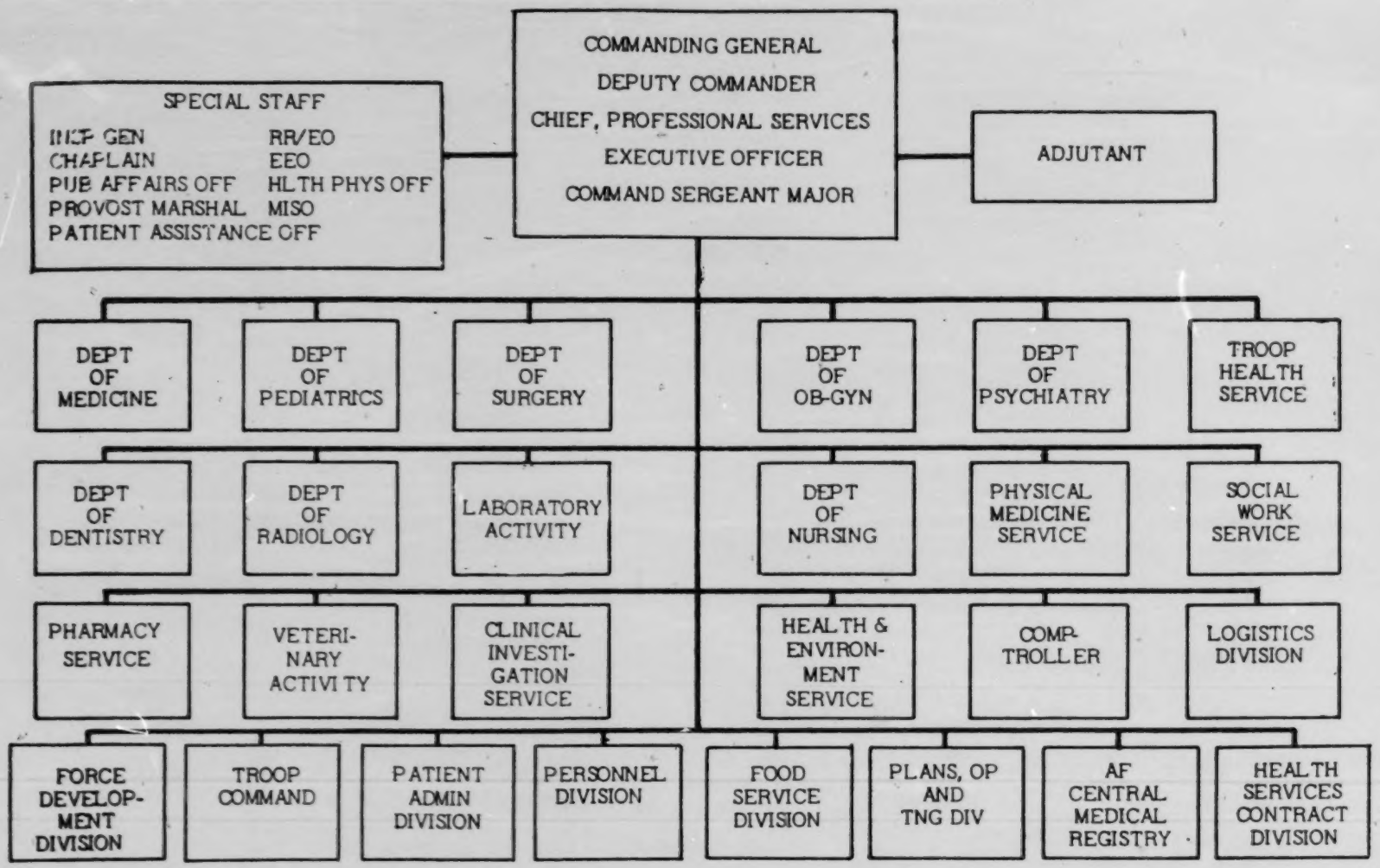


Figure 2.8

central record files, and ease of access for the exchange of ideas and information. These constraints can only be ameliorated through constant and concerted efforts of the primary participants.

The confusion of roles, functions, and responsibilities of the members of child advocacy councils is a striking example of the result of these factors. The assemblage of persons of diverse rank, status, and autonomy presents a formidable obsticle to clarifying the dichotomy of functions of case management versus case monitoring of child abuse/ neglect cases (see figure 2.8).

Another major constraint are personnel changes because of resignations and reassignments. These occur because of the military model, the upward mobility factors in all systems, the stress factors inherrent in providing human services, and the specific stress related to functioning in demonstration projects.

There are striking examples of personnel changes that have occurred during the past year. The chiefs of services of the Army Community Health Nurses, and Child Guidance and Adolescent Medicine at BAMC have resigned or been reassigned. The Social Work Services civilian social worker assigned to child abuse cases was transferred and another worker was assigned those responsibilities. The military Social Work Services main hospital section chief transferred to Germany, and another military social worker was assigned to that post; which includes direct coverage of the burn ward and supervision of the civilian worker in adolescent medicine. The pediatric secretary, who was receiving CA/N reports and referrals and acting as recording secretary during CPCMT meetings, was reassigned. The Provost Marshal, a CPCMT representative at BAMC, was reassigned to Germany and a new person was assigned his duties. Most recently, the pediatrician who was chairman of the CPCMT and has been assigned primary responsibility for CA/N over the past three years, resigned from the Army and no replacement has been designated. The ACHN who had represented her department, and assumed considerable case management responsibilities, has been transferred to Germany.

The project itself has also experienced substantial key personnel changes over the past two years, with only three of the original staff members remaining. During the past two years, the following project personnel changes have occurred: a new director and a new information specialist; conversion of the project nurse position to a social work position; the guidance counselor transferred to the Department of Public Welfare regional office, and her responsibilities were combined with those of the BAMC project coordinator; one project secretary also transferred back to the DPW Region IX office; and a new social worker was hired to provide direct services to families at BAMC. CARE's service delivery staff at BAMC now consists of one social worker who has the responsibilities of intake, assessment, case management, pediatric liaison, and pilot-testing 221-CARE as a crisis and referral telephone line.

Within the project staff at WHMC there have also been some personnel changes. One of the social workers was assigned, first part-time and then full time, to Randolph Air Force Base; the social worker assigned

as project coordinator resigned; the coordinator position was abolished and a social worker hired to continue providing direct services in response to referrals from the CAO; an additional social worker has been hired, to expand the role of pediatric liaison and to deliver direct services in response to referrals. These new assignments have stabilized the project staff to include two MSW social workers and one secretary at WHMC.

At Wilford Hall Medical Center (WHMC) the Air Force and civil service social workers' assignments have remained relatively stable. The Mental Hygiene Clinic has been temporarily relocated to Randolph AFB, pending completion enlargement of the hospital building at WHMC. One civil service social worker at Child and Adolescent Guidance Clinic (CAGC) resigned but was immediately replaced. There have also been some transfers and reassignments within the psychiatry department.

Even though the project's direct involvement at Randolph Air Force Base is somewhat recent, significant personnel changes have occurred there also. With the implementation of the Air Force regulation at RAFB, a psychologist was assigned as the Child Advocacy Officer (CAO). He was later reassigned to a different duty station and another psychologist assumed the CAO duties. At this time the project assigned a social worker at RAFB as a full-time representative. Soon, thereafter, the project social worker resigned from the project, joined the Air Force, and was assigned as RAFB CAO. A replacement project social worker was assigned to RAFB from the WHMC unit and continues in that position.

Many of the project personnel changes have required shift in emphasis on program components. These changes were basically necessary because of the differences in skills and professional training of the new personnel. Some minor project components have also been deleted because of personnel changes and the need to better utilize staff time in strengthening the more basic components.

It is significant to mention that these major personnel changes have occurred in addition to the normal rotation of medical staff. Since both BAMC and WHMC are teaching hospitals interns, residents, and other professional students in practicum placements usually rotate briefly through various departments and services. This is considered a normal constraint to continuity of services.

To reiterate, there have been many environmental constraints to implementation of a multidisciplinary service delivery system. The bureaucratic structures of the three principal participants are formidable. Negotiations within each bureaucracy have been accomplished in incremental steps on departmental levels, often requiring both vertical and horizontal transactions with several departments simultaneously. It has not been unusual to renegotiate one basic component with the same departments several times because of key personnel changes.

The primary structural and organization negotiations have focused on clarification of appropriate roles and responsibilities of departments providing basic services to families, such as: pediatrics, social work

services, and BCCW. The initial focus has been threefold: to negotiate each department's role and responsibility in CA/N cases; to describe the individual professional's functions in assessment and intervention with the family; and to clarify departmental interface with other disciplines, agencies, and child protective councils.

Once structural and organizational negotiations are accomplished the operational transactions follow. However, operational transactions are infinitely more complex, since they require consistent interface with other departments until several departmental approaches are synchronized into a multidisciplinary treatment team effort.

The remaining year will be devoted to revising and refining the service delivery system so that it may be internalized into the military environment.

CASE MANAGEMENT

Since the inception of the project, it has been apparent that there are crucial service delivery components missing within military environments. These components are necessary for the prevention, detection, and treatment of child abuse and neglect cases; and to the accomplishment of the project goal. The most significant gaps in the systems indicated a need for the following:

- A structured multidisciplinary staffing model and establishment of social work procedures at Wilford Hall Medical Center (WHMC) and Brooke Army Medical Center (BAMC)
- A uniform referral and reporting system at WHMC and BAMC
- Social work liaison between Pediatrics and Child and Adolescent Guidance Clinic at WHMC
- Conceptualization and testing of an approach to CA/N cases at Randolph AFB, a military installation with limited resources

The project initially attempted to resolve the problems by identifying the gaps within the system, suggesting ways the systems could respond, and offering project support in conceptualizing systematic development of the components.

After numerous abortive and frustrating attempts to modify the system's existing approaches, it was decided that the project would assume total responsibility for construction, pilot testing, evaluation, and revision of the components.

Each component presented an exceptional challenge and required considerable commitment of time. It was, therefore, decided to assign each component to an individual social worker as a special project. It seemed appropriate to involve those project social workers who had the knowledge, the relationships and the skills to accomplish the tasks within their respective environments.

Each of these components represents an enormous investment of the time and energy of project staff, and each required separate, specific negotiations. Consequently, the components have been detailed in individual sections by the staff member responsible for their implementation.

PATIENT PROFILE

Complete statistics of the cases referred to Project CARE for services during the period 1 July 1976 - 30 June 1977 have been separated out and the data have been computed on the following charts. Although narrative interpretations of the data have not been accomplished by the staff researcher, the statistics are somewhat self-explanatory. It was decided to include them in this documentaiton period with minimal inferences drawn, and to postpone interpretation of all data pending complete computation at the end of the third and final project year.

The total number of families referred to CARE was ninety-nine, and of those families, a high percentage were active duty military families. The sponsors of military rank between E1 and E7 accounted for a significant number of the referrals. Active duty military personnel were involved in 83 percent of the established cases,while retired families accounted for only 17 percent of the established cases.

It is significant that the largest number of referrals at WHMC were received by the child advocacy officer. At BAMC not a single referral was made through the Army Child Advocacy Officer. This seems, in part, reflective of two problems that have been addressed in another section of the service delivery system section. First, that there is no identified point of referrals at BAMC, and second that the Army Child Advocacy Officer is outside the service delivery system as a clinician.

The source of referral category further reflects the importance of effective liaison and communication between the military and civilian child protective workers. This inference can be drawn from the high percentage of cases referred from BCCW and GCCW units to the military installations.

Of the ninety-nine families serviced by Project CARE, thirty cases were abuse, seventeen cases were neglect, and thirty-seven were advocacy cases; others were potential abuse/neglect or a combination. It seems obvious that abuse cases are more easily identified; however, with sufficient personnel it is also possible to offer child advocacy services to families, which may be considered preventive in many instances.

There are 132 children involved in the ninety-nine families served by Project CARE. Of the total number of children 86 of them were under six years of age, with the next largest age group falling between 6 years and 15 years of age. The sex of the children was equally divided between male and female. The most frequently identified ethnic group was caucasian and approximately sixty-eight percent of the families served had no more than 2 children. In the "special child" category the problems most frequently encountered were ranked as follows: stepchild, nineteen cases; illegitimate

twelve cases; biracial, eleven cases. In forty-four of the cases the biological parent was identified as the alleged perpetrator, with fathers outranking mothers by approximately 5 percent.

Among the stress factors identified in the family situation were family separation, financial problems, child management problems, marital and family discord, psychiatric illness, and mental retardation.

A more complete analysis of all statistical data collected will be available in the next annual report.

PROJECT CARE STATISTICS
July 1, 1976 - June 30, 1977

	WHMC*	BAMC	RAFB	TOTAL
	No.	No.	No.	No.
1. Total number of families referred	61	27	11	99
2. Total number of families receiving services	58	26	8	92
Total number of children involved	73	38	21	132
3. Military data				
a. Military status				
Active duty	51	23	7	81
Retired	7	3	1	11
b. Current military assignment				
Fort Sam Houston	2	17	1	20
Lackland AFB	18	-	-	18
Randolph AFB	14	1	6	21
Kelly AFB	4	-	-	4
Brooks AFB	3	-	-	3
Other base/Texas	4	1	-	5
Other base/overseas	5	3	-	8
Other base/ U.S.	2	1	-	3
c. Branch of service				
Army	4	22	1	27
Air Force	46	1	6	53
Navy	1	-	-	1
Marines	1	-	-	1
d. Rank				
E1-E4	18	4	3	25
E5-E7	26	17	4	47
E8-E9	-	1	-	1
W1-W4	-	-	-	-
01-03	3	-	-	3
04-06	3	1	-	4
Unknown	2	-	-	2

*7 cases were transferred from WHMC to RAFB. These are included in WHMC statistics.

	WHMC	BAMC	RAFB	TOTAL
	No.	No.	No.	No.
4. Source of referral				
WHMC-CAO	15	-	-	15
WHMC-Dept. of Pediatrics	10	-	-	10
WHMC-ER	3	-	-	3
WHMC-Other Depts.	7	-	-	7
BAMC-Social Work Service	-	7	-	7
BAMC-Dept. of Pediatrics	1	4	-	5
BAMC-ER	1	-	-	1
BAMC-Other Depts.	1	3	-	4
BCCW	11	4	-	15
GCCW	3	-	-	3
RAFB-CAO	3	-	8	11
Self	1	2	-	3
DPW	1	2	-	3
Other	1	4	-	5
5. Case type				
Abuse	24	3	3	30
Neglect	6	6	5	17
Advocacy	20	17	-	37
Potential abuse/ neglect	5	-	-	5
Combination	3	-	-	3
6. Number of children involved by case				
None (pregnant)	1	-	-	1
One child involved	43	18	1	62
Two children involved	10	5	3	18
More than two children involved	3	3	4	10
Unknown	1	-	-	1
7. Children involved				
a. Age				
0-12 mos. old	12	5	-	17
13-24 mos. old	13	9	2	24
25-35 mos. old	3	-	1	4

	WHMC	BAMC	RAFB	TOTAL
	No.	No.	No.	No.
3-5 years old	16	18	7	41
6-10 years old	16	1	8	25
11-15 years old	9	4	1	14
16-18 years old	4	1	2	7
b. Sex				
Male	37	16	13	66
Female	36	22	8	66
c. Ethnic Group				
Caucasian	47	21	18	86
Black	7	3	-	10
Mexican-American	8	6	3	17
Oriental	1	-	-	1
Mixed	6	5	-	11
Other	2	2	-	4
Unknown	2	1	-	3
d. Position of each victim				
Youngest	21	11	6	38
Middle	5	5	5	15
Oldest	20	8	6	34
Only	19	8	1	28
Other	8	6	3	17
8. Family size				
1 child	19	8	1	28
2 children	21	7	3	31
3 children	8	6	2	16
4 children	2	2	2	6
5 children	2	1	-	3
More than 5 children	3	1	-	4
Pregnant	1	-	-	1
Unknown	2	1	-	3
9. Special problems/characteristics of children involved				
Illegitimate	8	3	1	12
Premature birth	4	-	-	4
Biracial	6	5	-	11
Diagnosed hyperactive	1	2	1	4

	WHMC	BAMC	RAFB	TOTAL
	No.	No.	No.	No.
Diagnosed mentally retarded	1	2	1	4
Chronic illness	2	3	-	5
Adopted child	1	2	-	3
Foster child	1	-	-	1
Stepchild	13	4	2	19
Physically handicapped	2	4	-	6
Other	3	1	1	5
10. Medical treatment				
None	34	21	8	63
Exam only	3	2	-	5
Outpatient treatment	6	-	-	6
Hospitalized	15	3	-	18
11. Prior abuse or neglect				
Abuse suspected	3	-	3	6
Abuse substantiated	9	1	-	10
Neglect suspected	2	-	5	7
Neglect substantiated	3	2	-	5
12. Alleged perpetrator				
a. Relationship to victim				
Biological parent	26	7	11	44
Stepparent	6	1	1	8
Adoptive parent	1	1	-	2
Other	2	-	-	2
Unknown	3	1	-	4
Child advocacy case	20	14	-	34
Number of families in which both parents were perpetrators	3	1	5	9
b. Age of alleged perpetrator				
Under 20	4	-	-	4
20-24	9	2	3	14
25-29	5	5	4	14

	WHMC	BAMC	RAFB	TOTAL
	No.	No.	No.	No.
30-34	6	1	3	10
35-39	3	-	-	3
40-44	4	1	-	5
45-49	1	-	-	1
Over 50	1	-	-	1
Unknown	5	1	2	8
Child advocacy case	20	14	-	34
c. Sex of alleged perpetrator				
Male	21	3	7	31
Female	14	6	5	25
Perpetrator unknown	3	1	-	4
Child advocacy case	20	14	-	34
d. Was military sponsor the perpetrator?				
No	19	7	4	30
Yes	16	2	8	26
Unknown	3	1	-	4
Child advocacy case	20	14	-	34
13. Data on parents of identified patient				
a. Mother's age				
Under 20	6	-	-	6
20-29	26	13	4	43
30-39	11	5	2	18
40-49	8	2	-	10
Unknown	7	6	2	15
b. Mother's ethnic group				
Caucasian	35	14	7	56
Black	5	3	-	8
Mexican-American	9	5	1	15
Oriental	3	2	-	5
Mixed	-	-	-	-
Unknown	5	2	-	7
Other	1	-	-	1

	WHMC	BAMC	RAFB	TOTAL
	No.	No.	No.	No.
c. Father's age				
Under 20	2	-	-	2
20-29	18	11	3	32
30-39	17	4	2	23
40-49	8	3	-	11
50 and over	1	-	-	1
Unknown	12	8	3	23
d. Father's ethnic group				
Caucasian	32	17	6	55
Black	9	3	-	12
Mexican-American	9	3	1	13
Unknown	8	3	1	12
14. Stress factors in family situation				
Marital separation	11	3	1	15
Military separation	7	7	-	14
Financial problems	19	8	2	29
Child management problems	24	10	7	41
Marital discord	18	10	3	31
Family discord	18	9	-	27
New baby/pregnancy	11	2	-	13
Abuse of spouse	13	1	1	15
Alcohol abuse	10	-	3	13
Drug abuse	3	1	-	4
Psychiatric illness	9	1	-	10
Mental retardation	2	2	-	4
Other	11	16	-	27
15. Case status after intake				
Abuse established	15	3	2	20
Abuse uncertain	2	-	-	2
Abuse invalidated	5	-	1	6
Neglect established	5	6	1	12
Neglect uncertain	1	-	2	3
Abuse and Neglect established	2	-	-	2
Potential abuse/ neglect established	8	-	2	10

	WHMC	BAMC	RAFB	TOTAL
	No.	No.	No.	No.
Child advocacy case	20	17	-	37
16. Legal action taken after referral				
None	52	23	8	83
OSI investigation	-	-	-	-
Child placed in foster care	1	3	-	4
Other	5	-	-	5
17. Services provided				
Intake and assessment (families)	40	14	8	62
Individual counseling (child)	7	-	-	7
Individual counseling (adult)	13	1	6	20
Marital counseling	2	-	2	4
Family counseling	5	-	-	5
Facilitative services	12	10	2	24
Parenting education, child management counseling	1	1	4	6
Other	4	-	-	4
18. Status (as of June 30, 1977)				
Family currently receiving services	5	5	7	17
Case closed, referred to another agency for services	30	10	-	40
Case closed, situation stabilized	9	5	1	15
Case closed, family refused services	9	4	-	13
Case closed, invalid	4	-	-	4
Case closed, moved	-	2	-	2
Case closed, spouse discharged from military	1	-	-	1

Section 2A

MULTIDISCIPLINARY STAFFING MODEL

SOCIAL WORK PROCEDURES MANUAL

During the early phases of the assessment of the environment, the project's emperical research revealed that the quality of case finding and services to families were grossly affected by the lack of basic procedures, consistently followed.

Although policies and procedures for the management of child abuse/neglect cases existed at both medical centers they were not consistently employed. Medical and psychosocial data were collected on a variety of forms, with pertinent data inconsistently recorded and frequently absent from the clinical records. This fragmented approach prohibited comprehensive assessment of medical, social, psychological, and environmental factors which might contribute to abusive or neglectful incidents or patterns. Direct contact with families was related almost totally to crisis intervention, or was in relation to a specific abusive or neglectful incident. There were no treatment plans based on the family dynamics, parent-child relationships, or situation stresses as causative factors. The exchange of information between disciplines occurred primarily during the twice monthly child advocacy conferences; and was little more than a "roll call" of cases. Communication about role definition of disciplines and clarification of responsibility was nebulous and resulted in fragmented services or loss of contact with families. This lack of overall case management, accountability, and responsibility highlighted the need for a more efficient and better organized service delivery system.

After several requests that representatives of the various disciplines submit descriptions of their roles and the standard operational procedures (SOP's) for their departments, it became apparent that simultaneous response from all disciplines could not be expected. The social work role was, therefore, selected as the focal point for clarification of role and responsibility. Consequently, a Social Work Procedures Manual was developed and pilot-tested by the project staff.

The purposes of the Social Work Procedures Manual are threefold: to provide a uniform and consistent approach to case management by social workers; to clarify interface with other disciplines, services, or agencies involved in the multidisciplinary approach to child abuse/neglect; and to stimulate professional interest in services to families beyond crisis intervention of the abusive incident.

The social work role, as described in the procedures manual, is innovative when contrasted to the traditional pediatric social work assessment. It includes a home visit, which is seldom accomplished in a medical setting. Therapeutic intervention is based on longer-term treatment plans rather than the brief, medically-related treatment usually associated with the pediatric social work role.

The social work intake and assesssment is comprised of: a minimum of three interviews with the family, one home visit; a medical records survey of the subject child and all siblings; the collection of appropriate collateral data; identification of high-risk factors; provision of crisis intervention; and formulation of a recommended treatment plan, to be presented for consideration by the Child Protective Council (CPC) or Child Protective Case Management Team (CPCMT).

The purpose of the social work intake and assessment is to intervene in situations where child abuse/neglect has been identified as a potential or actual problem, and to provide or initiate child advocacy services to improve the family's quality of life.

In order to provide consistency of approach, quality assurance, and professional accountability; several forms were developed for use in child abuse and neglect cases. These forms are: the family data sheet, or face sheet; the case flow work sheet; and the chronological log of referrals. Complete instructions for the proper use of each form are also included in the manual.

In addition to the case management forms there is also a code list for the types of abuse and neglect, a day care authorization form, guidelines for the use of child care centers, a monthly statistical report form, and a statement to parents form.

The manual also contains case recording outlines for intake and assessment, monthly summaries, a closing or transfer summary, and an outline for presentation of cases to the multidisciplinary team.

All the case work forms and case recording styles have been incorporated into a mock record, to demonstrate their utility. The mock record also illustrates the comprehensive social work approach to child abuse, neglect and advocacy cases.

THE SOCIAL WORK ROLE

There are several reasons for selecting an innovative social work role for assessment and treatment of child abuse and neglect cases. As previously mentioned, the social work role is a composite of the functions of the psychiatric, family services, and medical social work roles.

The psychiatric social work role is invaluable because it requires in-depth knowledge of the psychodynamics of the parent and the child. Knowledge of the psychodynamics of personalities will preclude a worker's tendency to relate entirely to the platitudes of "high risk" factors, or to a stereotype of the abusive parent or adult. Abusive parents are individuals from all socioeconomic circumstances; and may have psychological problems within all categories including reactive problems, personality level problems, neurotic or psychotic problems, or problems that may be related to limited intelligence, therefore, it is important to consider personality factors of the perpetrator and subject child, as well as the circumstances of the incident. It is equally as important to have adequate knowledge of normal child development, to ascertain whether the child is

presenting inordinate behavior which requires professional attention. Psychiatric social workers are accustomed to recognizing strengths and weaknesses in all family members and performing the types of collateral evaluations necessary to formulate a prognosis and select the appropriate treatment modality.

Family services social workers are adept in dealing with the gamut of psychological and environmental problems confronted by families. They are usually well versed in family dynamics, child and adolescent development and behavior, and they utilize a broad spectrum of community resources in meeting the needs of families. The home-visit has always been an integral part of the psychosocial diagnosis in good family service agencies.

Both the psychiatric and medical social worker function as members of a team, which is a skill unique in itself. The medical social worker develops the ability to rapidly and accurately diagnose problems, establishes relationships or rapport readily, and must be able to select those aspects of the problem that can be remediated quickly. The medical social worker also acts as liaison between the patient and his family, the medical staff, and other community treatment resources.

Since child abuse and neglect is often a medical problem that is reflective of a serious social problem and is also frequently the result of a psychological problem of some magnitude, the composite skills of the three social work models are necessary. The adults in abusive and neglectful situations are usually defensive and concealing, with a tendency to disguise or rationalize their behavior. These defenses are best dealt with when some degree of rapport can be established early in the process. Often the conditions that precipitate the abusive episode require immediate crisis intervention, and manipulation of environmental factors must occur simultaneously with the psychosocial assessment. The acquisition of supportive resources for the family provides a nuturing experience for the parents, thereby enhancing the therapeutic relationship.

The inadequate or inappropriate parenting in child abuse or neglect cases, except in reactive situations, is often indicative of an overall pattern of maladaptive behavior. Consequently, it is necessary for one member of the team to assume the responsibility for scheduling and tracking collateral services, for interpreting and diagnostic processes and treatment goals, and for informing the parents of their legal rights and responsibilities. In multidisciplinary teams it is the social worker who is best equipped professionally to assume the casemanager and case monitoring role, especially in cases where the problem is not primarily reaction to environmental stresses.

When an adequate multidisciplinary assessment is accomplished within the medical setting the protective services worker is provided with the professional judgement of several disciplines. This composite data can strengthen and augment court intervention. In cases where the need for legal intervention is questionable, the data should support a reasonable treatment plan for the family.

In addition to intake and assessment, the social worker seems the most appropriate team member to assume case management responsibilities. Where several persons from different disciplines, or even the same discipline, share equal responsibility for coordinating services for a family, it is almost predictable that communication and facilitation of services will break down. This is especially true when clients are, by nature of the problem, reluctant participants. Also, a large segment of the client population are multi-problemed families, in need of concrete services to alleviate immediate needs before psychological problems can be addressed. In medical settings, tangible services to clients are provided indirectly through a complex network of hospital and community resources. Most often it is the social worker who has knowledge of community resources, their eligibility requirements, and the quality of services offered. Within the medical setting, other members of the multidisciplinary team are usually highly specialized; and deal with selected aspects of the patient or family problem. Social workers traditionally have responded to the client within the context of his total personality and his interrelatedness of his environment. For these reasons, the social worker is essential to the diagnostic and case management practices.

FORMS

As previously mentioned, identifying data, intake, social history information, and collateral material were collected on a variety of forms by the pediatirc, psychiatry, and social work services. These forms, while adequate for the needs of the using services, are not designed to collect all the information crucial in child abuse/neglect cases. For example, most record forms within the military setting are military sponsor oriented and do not provide adequate family information. The fragmentation of information in clinical records was compounded by the absence of forms on which to collect significant data. Case records often did not include even brief information relating to the subject child's medical condition, laboratory findings, or the medical treatment administered. No single record contained all pertinent data from the initial case identification and intake through treatment and final closure. The available social work forms and idiosyncratic recording formats do not accommodate the collection of collateral data from other disciplines. There is no format to provide interim information, summary reports on the progress of the family, or the disposition of the case.

After an appraisal of the existing clinical records it was apparent that there was a need for several basic forms. It was also obvious that appropriate forms were necessary to provide structure and consistency in case management. CARE designed and produced the following forms to remedy these deficiencies:

The family data sheet serves three basic purposes. It is utilized as: a referral information sheet to record basic identifying information about the family, the source and date of referral, the codified type of abuse or neglect, and the circumstances of the referral; a case record face sheet for family data after the parents have been contacted; and a source for the collection of significant incidence and demographic data for research.

The instructions for the use of the family data sheet specifically suggest that information given by the referral source should include: a description of abuse/neglect incident; when and where it occurred; if the child has been examined in the hospital, clinic, or emergency room; the availability of the parents; and any immediate need for crisis intervention. If there is no physical or medical evidence of abuse/neglect the circumstances precipitating the referral should be recorded.

The case flow work sheet is a convenience form which serves a variety of utilitarian purposes. It has four parts. The first lists fourteen concrete service needs that may exist within the family. The list can be used to determine "at risk" factors, and gives some indication of the number and nature of stress factors present. It provides a brief and convenient overview of the need for intervention in the areas of tangible or human resource services. It also allows for some appraisal of the family's ability to adequately provide for tangible needs, and alerts the worker of when to shift the focus of the intake toward more interpersonal or intrapsychic factors.

The second part of the case flow sheet is for recording medical records review information. This section serves to remind the worker to review the medical chart of the subject child, and of siblings, for previous abuse/neglect incidents; and to identify other significant medical treatment, injury, or neglect patterns. It also helps in the identification of past or present physical conditions which may be contributory to the "special child syndrome" in the subject child or a sibling. This section also alerts the worker to review medical and/or psychiatric records of the parents, if indicated. Periodic monitoring of medical records also substantiates the parents' compliance with, or failure to follow medical recommendations.

The third section of the case flow work sheet lists the collateral resources most commonly contacted during the assessment and treatment phases. The purposes of the contacts are to request reports of special services already rendered; to request, by consult, special services needed for crisis intervention; or to accomplish a more definitive psychosocial diagnosis on which to base a viable treatment plan. This section also serves as a tracking form for the request of collateral services reports or therapeutic intervention.

The fourth section indicates several therapeutic modalities and provides the case manager, or case coordinator, with specific information about the kinds of therapeutic services family members, or the family unit, are receiving; as well as identifying the assigned therapist. This approach should disallow the vague and nebulous reports of "working with" or "following the family." If the case is shared by therapists it serves as a reminder to collaborate periodically to insure commonality of treatment goals. The case manager also should utilize this section to determine when a modality is begun, terminated, or replaced by another more appropriate to family or individual needs, dynamics, or movement in therapy.

The chronological log of referrals provides a variety of information. It gives basic demographic data about the subject child and siblings. The code number indicates the severity of the problem. The source of referral gives some indication of case finding capabilities of referring agents. The log can also be used to determine the time involved in processing patients through the system.

The family data sheet, the case flow work sheet and the chronological referral log should enhance the administrative, case finding, and case management functions in child abuse/neglect cases. The code list, day care forms, and statistical forms are useful in facilitating services, and providing consistency in the description of types of abuse/neglect.

CASE RECORDING FORMATS

There are basically four case recording formats in the manual, intake and assessment, monthly summary, closing summary, and outline for case presentation to a multidisciplinary group.

One purpose of the case recording formats is to provide an outline for intake and assessment and compile specific categories of information pertinent to all cases. It also provides for the inclusion of material unique to a specific case. Most importantly, it provides a consistency of approach. Hopefully, this approach will become internalized and lead to a more effective diagnosis of a wide spectrum of precipitating factors.

The purpose of the monthly summary is to encourage a goal and task oriented approach to case management. Hopefully, it will remind workers that human dynamics are not static and that treatment goals may need modification in view of new information or insight.

The closing summary format is used to appraise: the accuracy of the assessment; the effectiveness of the selected intervention; the degree of pathology within the family; and, to some degree, to predict the degree of stability achieved by the family.

The primary intent of the Social Work Procedures Manual is to encourage the development of an innovative social work role which will be more effective in relating to child abuse/neglect cases. Secondly, it provides forms that consistently collect significant case data. Finally, it suggests case recording formats that provide for a definitive diagnostic and multidisciplinary approach to each case.

Section 2B

REFERRAL AND TRAUMA INDEX SYSTEMS

One of the first definable obstacles to the identification and management of child abuse and neglect cases is the procedural ambiguity of referring and reporting cases within the hospital environment. On military installations most of the child abuse and neglect cases are first identified by pediatricians; however, there are no written procedures for referring the cases to social work services, or reporting them to the legally mandated community agency. Gianoukos (1974), in an unpublished MSW thesis, has concluded that "the medical person coming in contact with a case of suspected abuse or neglect needs specific procedural steps to follow." At BAMC the procedures for referral, reporting, and interface between pediatrics, social work service, and BCCW have been informal, inconsistant, and generally ineffectual. Procedures are transmitted by "word of mouth" during the general orientation of medical staff. The community pediatrician has usually assumed the primary decision making responsibility for all cases in the pediatric department. However, during his absence or unavailability the referral of cases is considerably diminished. Cases are sometimes referred to the social worker by other pediatricians during ward rounds, when there is an opportunity to discuss the situation and erase doubts as to the appropriateness of the referral. If there were specific guidelines to raise the level of awareness of indicators of abuse and neglect, and concise procedures for referral for psychosocial assessment, it is anticipated that case finding would increase appreciably.

During Project CARE's tenure at BAMC there has been no uniform reporting or referral system, nor has a central trauma file been in existence. Without a single, well-publicized point-of-entry for reporting of suspected CA/N cases many reports are not made or are delayed, because the reporter does not know who to call. Also, processing of a report might be delayed because the call was given to the improper source. Often a case reported to BCCW is not known to be military until sometime into the investigation and is, therefore, handled by a BCCW worker unfamiliar with military resources.

A specifice point-of-entry would facilitate the establishment of a central trauma index, a most valuable tool in the process of detecting and managing CA/N cases. Often a single suspicious injury may not sufficiently suggest child abuse, but when compared with other questionable injuries to the child it takes on a different significance. A central trauma index could provide physicians with history of previous injuries and circumstances precluding the need for a medical record survey. The practice of "hospital shopping" among abusers is well known, even though it is more difficult in the military. However, seldom does one doctor follow a family or even one member of a family. This fact, plus the time required to thoroughly review medical records, usually means that the attending physician is unaware of previous trauma. Unique to the military is the patient's, (or parents), access to the medical record; making notations of CA/N impractical for future reference as such notations can be easily removed by the parents.

The detection, reporting, and referral of child abuse/neglect cases at BAMC has been sporadic and informal. Consequently, different disciplines within the environment have devised individual methods of responding to child abuse and neglect situations. Neither the BAMC Burn Unit nor the Main Emergency Room have a child abuse/neglect protocol. At the workshop Burns - As Abuse presented by Dr. Donald Pfeifer and Ms. Catherine Ayoub at the Second Annual National Conference on Child Abuse and Neglect in Houston, Texas in April 1977 burns were presented as a primary form of abuse and neglect. In their Tulsa, Oklahoma study all inflicted abuse was by scalding. In cases of injury due to neglect, burns by open flame and hot objects as well as scalding were found. Although children are frequently treated at the burn unit at Brooke, seldom are the families referred to the military department or civilian agency responsible for suspected abuse/neglect cases. Likewise seldom is a case referred to a social service department by the Main Emergency Room. It is imperative that emergency room staff members be trained in the detection and reporting of child abuse/neglect for, as one study revealed, 50 percent of children accident victims come to the hospital between 5:00 p.m. and midnight (Halter & Stanford, 1964). Other observations have revealed that a significant number of abuse/neglect cases are admitted on weekeneds. Yet the Main Emergency Room has no policy for the management or reporting of abuse/neglect cases. In fact, the corpsman who is the first medical contact in the ER, and makes the first decisions about disposition, has no training whatsoever in the detection of child abuse/neglect.

The Provost Marshal Office (PMO) has a representative on the CPCMT but has no standard operating procedure (SOP) for child abuse/neglect cases. Consequently, cases involving suspected abuse/neglect on post are processed with only informal provisions for referral to the pediatric social worker or 221-CARE. On one occasion the Armed Forces Division of the San Antonio Police Department called the PMO about the possible abandonment of the twelve-year-old daughter of an active duty Army member. Although social service involvement was asked, the PMO was unable to supply SAPD with the name or telephone number of anyone with military sanction to handle such a case. The Fort Sam Houston day care center usually calls the CA/N pediatrician when they suspect a child is being abused or neglected, and the post schools call BCCW. Adolescent and Child Psychiatry (formerly the Child Guidance Center) reports directly to BCCW. Pediatricians generally report suspected CA/N cases to the pediatric social worker on his twice weekly rounds, except for emergency cases which are reported immediately.

These illustrations reflect the need for an identifiable point-of-entry at BAMC. In March 1977 at the request of the CPCMT, Project CARE assumed responsibility for a six-month pilot study of the point-of-entry and referral systems. This included installation of a special telephone line with the designated number 221-CARE, and the establishment of a Central Trauma Index File.

Although the 221-CARE line had been established several months prior to Project CARE's pilot study, key departments were not officially notified of the number nor were procedures developed for accepting referrals. The

number was poorly advertised on the post and was not designated as solely for reports of child abuse/neglect. This, and the fact that the telephone line has always been inadequately manned, has presented obstacles to the pilot study. At first, responsibility for answering the line was added to the duties of the secretary of the Adolescent Medicine Department. Originally she was not given enough telephone capacity and then the position was abolished altogether. The phone was left totally unmanned for several weeks. Although it is expected that the referral line will be manned 24-hours a day in the future, at present the phone is answered only during regular duty hours. The number of calls has been few, presumably because of lack of response or lack of publicity. Of the calls received some have been inappropriate because they were not reports or referrals of child abuse/neglect.

It was hoped that, with the establishment of an easily remembered twenty-four hour referral line on post, more official and non-official sources would report suspected cases of CA/N involving military personnel and their dependents. Also, with an identified point-of-entry it was felt that a uniform recording system and central trauma file could be established; that more accurate statistical data could be compiled; and, because the phone was being answered by a worker with a MSW degree, crisis intervention could be initiated.

Although Army regulations provided general guidelines to address child abuse/neglect, specific departmental SOPs had not been developed by the various departments. As negotiations proceeded, the need of each department to specify their policy and procedure in managing child abuse/neglect cases became apparent. Negotiations with all factions, including Bexar County Child Welfare (BCCW) and Social Work Services (SWS), were necessary as interface between them was informal and sporadic. In some areas it was not known what support and services a particular department, such as the Provost Marshal's Office, might provide.

Proceedings were initiated with BCCW, SWS, and Pediatrics, because of the close alignment with Project CARE in the management of CA/N cases. Clarification of roles, procedures, and the most efficient delivery of services were the topics of the negotiations.

BCCW is an investigatory agency. They have the ultimate authority for validating or invalidating cases of suspected child abuse/neglect. If the placement of a child or court action is necessary BCCW must initiate and direct the plan. Reports of child abuse or neglect are taken by a point-of-entry worker. In an emergency situation this worker will go immediately to the site. The point-of-entry phone is manned until 1:00 a.m. every week night, from 12 noon - 1:00 a.m. Saturdays, and from 1:00 p.m. - 10:00 p.m. on Sundays. At all other times reports must be made to the police department or the statewide telephone number designated for the reporting of CA/N.

A special intake unit is responsible for all cases involving Army personnel. This means that one worker and one back-up worker are designated to handle Fort Sam Houston (FSH) cases. The BCCW intake worker makes an unannounced home visit to the family suspected of CA/N, explains

that a report has been made, and discusses the family situation with the members present. The parents are asked to supply the names of neighbors and relatives or friends from whom the intake worker can gather collateral information. Based on the family visit and collateral information, the intake worker decides disposition. The case is either invalidated and closed or validated and referred to an ongoing worker. If the situation is serious enough to warrant immediate removal of the children from the home, the children are placed in the San Antonio Children's Shelter on a temporary basis. If the children are to be out of their home for more than a week a foster home is found for them.

The pediatric social worker at BAMC receives a large portion of his referrals from BCCW, but does not become involved with a family until BCCW has made their initial home visit and has validated the case. In the rest of the cases, referred mainly by pediatricians, the initial social work contact is usually made by the pediatric social worker. Usually children referred by pediatricians as CA/N victims are on the ward or in the clinic. The pediatric social worker, therefore, has ready access to the parents in most cases. The pediatrician will refer the family to the social worker and will prepare them for this contact, but there is no set procedure for reporting to BCCW or notifying the family that such a report has been made.

Usually the child is kept in the hospital or the clinic until the pediatric social worker has talked to the family and, if possible, reviewed the medical records of the subject child and those of all other children in the home. When the pediatrician and the social worker agree that the child will be safe in the home, and is medically able, the child is released from the hospital. If the attending pediatrician and the social worker do not agree the community pediatrician is consulted. Although, by job description, the pediatric social worker is able to provide long-term counseling and to manage child advocacy as well as abuse/neglect cases, his caseload is usually too heavy to provide these services.

Meetings were held with the Community Pediatrician to clarify and negotiate the pediatric child abuse neglect SOP. We were concerned with the detecting and reporting of child abuse/neglect cases. It was our intention to establish a child abuse/neglect protocol at BAMC.

BAMC is a teaching hospital and interns and residents attend the twice weekly rounds conducted by the Chief of Pediatrics. These are also attended by the pediatric social worker and the Project CARE social worker. The social workers attend rounds to aid in the finding and management of cases by being available to the pediatricians for easy reporting, and to gather collateral information from other ward personnel for the management of cases. The interns and residents are on a rotating schedule, and it is hoped the social workers' presence will impact on them enough to keep them aware of abuse and neglect cases when they are assigned elsewhere.

After negotiations with the Community Pediatrician and the Chief of Pediatrics, several items were included in the guidelines for managing child abuse and neglect cases at BAMC. In all cases of suspected abuse/

neglect, regardless of the nature and extent of the injuries, the child will be hospitalized. This will assure the safety of the child and will allow an evaluation of the family to be initiated. The physician will check the trauma index file for previous reports of abuse/neglect. (The logistics will be addressed in a later section of this report.) Specific laboratory tests should be done routinely on the child, including radiologic examination of skull, chest, and long bones; and a bruising and bleeding disorder screen. Funduscopic examination, and careful examination of the perineal area should also be done routinely. Color photographs showing face and injury should be taken whenever there is visible evidence of trauma. The physician should elicit detailed facts concerning the injury from the parents or caretakers.

The physician should call 221-CARE with appropriate referral information and within twenty-four hours should consult with the Community Pediatrician to confirm the diagnosis of suspected child abuse or neglect. The ward physician, Community Pediatrician, and the social worker will decide who will notify BCCW of the case and when. In cases where the child is DOA, or has severe and substantial life threatening injuries, or if the parents threaten to remove the child against medical advice, BCCW and the PMO will be notified immediately. The ward physician, Community Pediatrician, BAMC, and BCCW social workers will consult to determine when to discharge the child, and if other children in the home need medical evaluation. The Community Pediatrician will report the medical findings in the case at the next CPCMT meeting. Negotiations regarding a checklist of examinations to benefit the physicians are not yet complete. There is a Pediatric Emergency Room, staffed from 6:00 p.m. - 10:00 p.m., Monday through Friday, to handle all pediatric emergencies except burns, bites, cuts, and poison. These injuries are seen at the main emergency room at all times.

As stated previously, the Main Emergency Room has no child abuse/neglect protocol. When a patient enters the Main Emergency Room he is first seen by a medical corpsman who, employing algorithms, determines the first plan of action. Although the corpsman is the first contact he has had no training in the detection of child abuse and neglect. The attending physician has sole responsibility for detecting such cases.

If abuse or neglect is suspected, the resident on duty at the nursery is asked to examine the child. If this physician concurs, the Community Pediatrician or the physician on duty at the Pediatric Ward is notified and asked to examine the child and, if he agrees with the diagnosis, to admit the child to the ward. The child is then transported by his parents from the Main Emergency Room to the Pediatric Ward for examination and admittance.

Identifying data and the illness or injury of all patients seen in Main Emergency Room from 4:00 p.m. - 7:00 a.m. are written into a log and also onto a list of admissions, kept in the nurses' office. The Community Pediatrician reviews this list to identify possible cases of child abuse or neglect. Because of a one to seven day delay in the reviewing of this list, it was suggested that the pediatric social worker and the Project CARE social worker rotate the reviewing of the list each morning.

and consult with the Community Pediatrician on suspicious cases. However, because of the change in personnel and other factors, this arrangement has never been finalized. In fact, since the previous CA/N pediatrician has left the Army, it is not known if anyone is reviewing the admissions list for possible CA/N cases. Further negotiations with Main Emergency Room have been delayed until negotiations with the Pediatrics Department has been completed.

In regard to the logistics of the 221-CARE referral line and central trauma file many facotrs are still to be negotiated. The line has been installed at Project CARE since March 1977 and, except for an undeterminable period during which it was out of order in June-July 1977, it has been manned during regular duty hours. The secretary answers the call by saying 221-CARE and her name. The name of the caller is not asked. The call is then transferred to the 221-CARE intake social worker or her backup. The intake social worker collects the necessary data on the 221-CARE Referral Form.

In case of medical emergency, the caller will be told which emergency room should see the child and the emergency room is notified of the impending arrival. In cases of domestic disturbances, or other social emergencies where the child may be at risk, the appropriate emergency intervention agency is called. If the incident is on post, the military police are notified; if it is off post, BCCW or the San Antonio Police Department (SAPD) are notified. The pediatric social worker is also notified immediately in emergency cases, so that he and the intake social worker can decide who will assume case management responsibilities during the intake and assessment phases.

It was intended that during non-duty hours, on weekends and holidays, the line would be answered by pediatric ward personnel and the line was installed on Ward 42C in March with the approval of the Chief of Pediatrics. However, because of the possible decision-making duties required in answering the line, it was decided that only the physician "on call" would have the responsibility for answering the line; unless he was busy with an emergency. Handling the line necessitates knowledge of non-medical resources and training in this area for those responsible for the line on the ward would be necessary. This will require the sanction, cooperation and participation of the Chief of Pediatrics. Negotiations for this training have not yet begun.

One of the most difficult areas of endeavor has been the central trauma index. Such a file is necessary for several reasons, including the collection of statistical data and the detection of child abuse/neglect cases. Knowledge of previous incidents will help the physician in diagnosis and the social worker in the management of the case. As hospital and doctor shopping are common practices of abusers, even in the military, such a file becomes even more necessary. Since medical records are often hand carried from one service to another by the patient or parents, any notation of CA/N can be easily removed. Therefore, the question of the need for a duplicate record, as well as the central trauma index has been raised. At present, we are attempting to establish a central trauma index for FSH and the duplicate record question has not

been addressed. It is expected that eventually all military installations in San Antonio will be associated with the index.

The major questions raised in regard to the index concern the rights of the families in the inclusion and removal of names on the list. These questions include: Will a family be notified when they are included in the index? Will they be able to see the listing and ask that incorrect or invalidated material be removed? Will a name be added at the time of the initial report or after an investigation to determine validity has been completed? These and other areas have not yet been addressed by the various services, including patient administration division (PAD) that will be involved with the index.

Other questions concern the information on the card itself. Should it include only identifying data or a complete history of all non-accidental trauma? If the medical history were a part of the data it would eliminate the need for the doctor to review the entire medical record. Also, knowledge of prior incidents of suspected abuse/neglect would aid in making a diagnosis.

It is imperative that the index be available to physicians and social workers twenty-four hours a day so, if a child is seen after duty hours or on the weekend, it can be consulted. It was first suggested that the index be kept in the locked narcotics cabinet in the pediatric ward. However, the chief of pediatrics vetoed this suggestion becuase of the number of people, professionals and paraprofessionals alike, who have access to the cabinet. Another suggestion was to house the index at PAD, which is also open twenty-four hours a day. As it is anticipated that information would be given over the phone, a code system would have to be originated for use by doctors and social workers with a need for the information. However, as there have been no negotiations with PAD, these remain suggestions.

In conclusion, there have been many constraints to the pilot-testing of the 221-CARE referral line and central trauma file. They range from difficulty in arranging meeting times with various personnel to total loss of key personnel. Negotiations have not been initiated with the burn unit, the Provost Marshal, or the day care center. Final approval by the Chief of Pediatrics is required before the main emergency room protocol can be completed. Although there are many areas requiring decisions from PAD, we have not yet confronted this department. Much work still needs to be done in formalizing interface between SWS, BCCW, and Project CARE, during the final year of this project.

Section 2C

THE PEDIATRIC/LIAISON WORKER

The traditional pediatric social work role follows the medical model of a multidisciplinary team approach to the prevention, diagnosis, and treatment of health related problems. The team consists primarily of the physician, the nurse, and the social worker. The rationale for the clinical model is based on the theory that the total health needs of an individual can best be managed by a variety of health professionals, each contributing their skills and expertise.

The pediatric social worker should be located within the immediate area where pediatric services are housed. The worker should be as available and visible to the pediatric ward as her team member counterparts. The pediatric social worker offers a variety of services which include: direct social work services to pediatric patients and their families, referral and collaboration with community resources, consultation to other disciplines within the hospital setting and the community, education, and program consultation and research.

The role of the pediatric social worker in child abuse/neglect conforms to the medical model described earlier. Casework and family therapy, the major components of direct social work services, are the preferred processes for utilization in the case management of child abuse/neglect. The diagnosis and treatment of child abuse/neglect is most effective when a social worker is involved in the diagnostic process. Child abuse/neglect is a multifaceted family problem, with its most obvious manifestation as a medical problem. Just as the skills of a qualified physician are needed to diagnose and treat a medical problem, so is the competence and expertise of a pediatric social worker necessary to evaluate and treat the psychosocial elements of the problem. Early involvement of the social worker is particularly important because parents are usually defensive and distrustful of those who offer assistance. These defenses are not easily overcome, but can best be dealt with a one-to-one therapeutic relationship that is initiated early.

Referral and collaboration with community resources for the resolution of crisis within the family system are common in child abuse/neglect cases. The alleviation of obvious environmental needs must be handled before psychosocial assessment and needs are identified and addressed. Such referrals may include emergency, temporary, or permanent placement of children in confirmed child abuse/neglect cases. After diagnosis and treatment plans are completed, abusive parents are identified and often need referral to outside agencies for family therapy and child management. Case consultation with other disciplines is inherent in the clinical management of pediatric problems. Consultation for case management of child abuse/neglect is of paramount importance; in that the medical, or team, model emphasizes the sharing of professional knowledge to enhance the total evaluation and treatment of the problem.

Program consultation is another component of the pediatric social work role in child abuse/neglect. The pediatric social worker should participate in the planning of hospital and clinic policies, services, and procedures. Special emphasis should be placed on those policies regulating the hospital guidelines for case management of child abuse/neglect. Program planning and a system for measuring accountability are important for the deliverance of pediatric social work services. Services should be analyzed in regards to quality and effectiveness, as well as quantity and efficiency. Research serves not only to measure services, but also to justify the need for a pediatric social worker. This will be of paramount importance at WHMC where measurable accountability is required to justify the need for a service that has previously not been offered. Project CARE is exploring the establishment of an instrument to categorize and enumerate all pediatric referrals outside the area of child abuse/neglect, and formal child advocacy referrals to the project.

Educating other health disciplines as to the role model and services of a pediatric social worker contributes to better staff relations and the overall caliber of services rendered to pediatric patients and their families. The didactics of management of child abuse/neglect and the overall social worker role are especially important at WHMC, where there has never before been a pediatric social worker. There is confusion as to the role delineation of a pediatric social worker, the child and adolescent guidance clinic (CAGC) psychiatric social worker, the Bexar County Child Welfare protective services worker, and the Project CARE social worker. The two pediatric department chairmen at WHMC express a desire for the services of a pediatric social worker, but the specific services have not been spelled out. The pediatric residents at WHMC rotate assignments between the ward, clinic, nursery, and modular clinic. The introduction of an on-going educational program for pediatric residents would improve the identification and utilization of the pediatric social worker. Presently, the pediatric residents at WHMC receive CA/N training from the Pediatric Ward chairman. Thus far, the presentations have been primarily limited to the medical appraisal of child aubse/neglect, with a cursory review of the social implications. Project CARE, CAGC and pediatrics plan to further explore the educational component. Efforts will be made to identify the training needs of the medical staff, in conjunction with the priorities the project will determine for its final year.

The present model for case management of child abuse/neglect and child advocacy at WHMC places the responsibility for service delivery under the direction of the CAGC. While this psychiatric clinic provides a multidisciplinary approach to case management, it also represents considerable deviation from a traditional medical model. The psychiatric social workers of the CAGC are physically separated from the pediatric services, and do not routinely provide casework services to the pediatric patients and their families. Presently, most child abuse/neglect cases identified at WHMC are those displaying obvious evidence of trauma. The diagnostic process concentrates on the collection of incident, medical, social, and emotional data by the pediatrician. While this represents an appropriate approach, the diagnosis and treatment of child abuse/neglect would be enhanced by the early involvement of a social worker.

Project CARE is currently attempting to bridge the gap between CAGC and pediatrics by creating a liaison role. The liaison role is intended to promote casefinding for child abuse/neglect, to provide crisis intervention for the pediatric patients and their families, and to facilitate case management procedures between pediatric services and CAGC. An additional objective of the liaison role is to assess the need for a pediatric social worker role at WHMC. Present negotiations with the pediatric department have established the pediatric ward and clinics as an area of priority where the liaison staff member can simultaneously casefind, provide crisis intervention, and assess the pediatric social work role. The liaison worker conducts weekly ward rounds and receives referrals on child abuse/neglect cases admitted to the ward and assigned by the CAO to Project CARE. Cases that are suspected or diagnosed as failure-to-thrive are also mandated to the liaison member. The liaison worker is also available to provide child advocacy services to ward patients as a secondary work priority.

The pediatric service offers a variety of sub-specialty clinics. Present negotiations are aimed at examining which clinics serve patients who would most appropriately require child advocacy and crisis intervention services. There are thirteen sub-specialty clinics, ten of which meet one day per week. Two clinics meet once monthly and the pediatric behavior clinic meets twice monthly. The pediatric behavior clinic is the only pediatric clinic routinely attended by a social worker. A Red Cross social worker assists this diagnostic clinic by providing a social history on each new patient. The Red Cross provides social work services to WHMC on a part-time basis. It has not been ascertained as to how effectively the Red Cross fulfills the needs of WHMC, nor what the utilization rate of these services demonstrates. A closer look will be taken at the pediatric clinic system, to determine a priority of one or two clinics to be routinely attended by the CARE liaison staff member. Presently, the liaison worker receives clinic crisis referrals, medically complicated, failure-to-thrive, and potential or valid child abuse/neglect cases referred to the project.

Project CARE, during its final year, will also develop liaison with the OB-GYN department at WHMC. Last year, Project CARE provided a twice weekly parenting education presentation aimed at enhancing child care and preventing child abuse and neglect. This ward presentation was aimed primarily at first time mothers, but was open to all mothers on the ward. Negotiations for Project CARE services to the OB-GYN ward for the third and final year are currently underway. The parenting course has been eliminated and the liaison role with OB-GYN will encompass a new dimension. The CARE liaison worker will be avilable to the ward as a consultant. Consultation would be provided on high-risk medical and social situations, which are potential child abuse/neglect or child advocacy cases. Appropriate social service referrals to both military and civilian resources would be provided, as well as the direct provision of casework services in urgent, crisis situations.

Section 2D

CARE SERVICES AT RANDOLPH AIR FORCE BASE

The service delivery system, as conceptualized by Project CARE, is constructed for use in military installations having a full complement of medical and human services resources. However, as CARE units at Wilford Hall Medical Center (WHMC) and Brooke Army Medical Center (BAMC) became active in providing services, a significant number of referrals were received from Randolph Air Force Base (RAFB). Initially the RAFB cases were assigned to one worker, to conserve time and travel and to have a project person become familiar with the installation. It soon became apparent that RAFB was a different environment in terms of resources available. It was then decided to compare RAFB to other installations with limited military and civilian resources, and to devise a service delivery system which would be functional in the face of significant constraints.

This section consists of a discussion of the rationale for the assignment of project staff to RAFB, an assessment of the environment, some of the systemic constraints which have been identified, negotiations accomplished within the environment, and the project negotiations necessary to fully implement services.

A major objective of the service delivery components of Project CARE is to examine a typical installation, RAFB, as one lacking the wealth of resources available at large medical complexes. A project worker has been assigned to RAFB to explore the possibilities of devising a systemic approach to child abuse and neglect on a military installation with limited internal resources in response to Air Force regulation 160-38 (Child Advocacy Program). This test will also allow CARE to demonstrate and evaluate the project social work model within a different environment.

The primary goal is to clarify the roles of professional personnel in the identification and management of child abuse and neglect cases, and to formulate guidelines for a viable child protective council. It is anticipated that the procedures developed can be replicated at military installations with similar limitations.

Randolph Air Force Base is a major Air Force installation. In addition to its flying training mission, there are several tenant organizations located on base. The Air Training Command Headquarters has the responsibility of recruiting new personnel and providing them with initial military technical and flying training. It directs the activities of fourteen bases in eight states and a network of field training detachments located on Air Force bases throughout the world. The Air Force Military Personnel Center has responsibilities which include assignments, promotions, and retirements. The U.S. Air Force Recruiting Service, also located on RAFB, supervises thirty-two recruiting detachments, approximately 1,000 recruiting offices, and some 1,700 recruiters throughout the fifty states, Europe, and Puerto Rico. The Community College of the Air Force is an Air Force-wide educational program uniting on-duty Air Force Technical education, and

off duty education acquired from civilian schools into programs directly relating to the non-commissioned officer career development. A Military Airlift Squadron is also located on base, with the mission of providing emergency transportation for burn team technicians from BAMC and delivering them throughout the United States.

Six communities in Guadalupe, Bexar, and Comal counties are located in the RAFB area. Universal City is located outside the front gate of RAFB, and has a population of approximately ten thousand; a fivefold increase since 1960. The communities of Schertz, east of Universal City; and Live Oak, west of Universal City, comprise about seven thousand residents. West of Schertz, and about three miles from RAFB, is, the community of Cibolo with a population of five hundred people. Bordering Universal City on the north is Selma, a community with a population of two thousand. Located west of Selma is the community of New Braunfels with a population of approximately seventeen thousand seven hundred persons. A substantial portion of the populations in these communities is composed of active duty and retired military personnel. Growth for the area by 1990 is expected to more than double the present population. To foster orderly growth within the area, the community council of the Randolph region was established in 1970. Membership includes the mayors of the six regional communities and the commander of the 12th Flying Training Wing of Randolph AFB. The council identifies problem areas within the region and constructively supports community efforts of mutual benefit.

These six surrounding communities are quite limited in even the most basic human services resources. Each of the three counties has a child welfare and child protective unit within their respective Department of Public Welfare. These units constitute the only civilian community services available to families in need of child advocacy resources.

Due to the limited resources of the neighboring communities there are few alternatives available for treatment of child abuse/neglect situations. The resources in the city of San Antonio are primarily used to provide services to families involved in child abuse/neglect. The airbase has few resources for the identification, treatment, and follow-up of families. The base hospital is limited to out-patient care and the mental health clinic is set up to provide services only to military sponsors. Since Air Force Regulation 160-38 was published a Child Advocacy Officer/Social Worker position has been created in the Mental Health Clinic. Cases of child abuse and neglect requiring hospitalization are referred to WHMC or BAMC when injuries are severe. Certain suspected cases requiring extensive laboratory tests must also be referred to BAMC or WHMC. Consequently, in the past, RAFB developed a pattern of referring almost all child abuse/neglect cases to these larger medical complexes.

The Randolph Clinic has a staff of 210. There are 15 physicians; 11 nurses, both military and civilian; and 24 additional officers in various medical support roles. There are 120 enlisted members and 52 civilians serving in a myriad of health specialties. Since the medical unit at Randolph AFB has only out-patient capability, all admissions are accomplished at Brooke Army Medical Center or Wilford Hall USAF Medical Center. Medical components available on an out-patient basis are as follows Acute

Clinic, which handles all emergencies; General Pediatric Clinic, which treats children through age twelve years of age; General Medicine Clinic, which treats all chronic and routine medical problems. Randolph's Mental Health Clinic, which is specifically responsible for active duty sponsors, is staffed by a psychologist, a social worker, and a psychiatric technician. The social worker's primary mission is as Child Advocacy Officer and CHAP Officer. Gynocology, optometry, dental, and pharmacy services are also available within the clinic. The Flight Surgeon's Office is exclusively for the medical problems of flying personnel.

Educational facilities on Randolph AFB accommodate pupils from nursery school through the 12th grade. The Randolph Child Care Center is available to children of both active duty and retired military personnel between the ages of six months and ten years. The children of military guests are also eligible for child care services. There is an elementary school and a high school located on RAFB, which operate under laws of the State of Texas and constitute the Randolph Field Independent School District.

A Family Services organization is also located on RAFB with the primary mission to provide information and assistance to military families in the Randolph area. A temporary loan service, providing basic housekeeping equipment, is available for newly arrived personnel. Volunteer baby sitting services are available to parents with unexpected emergencies, or to enable mothers to keep medical appointments. Training classes are also sponsored by Family Services in toilet training children, helping parents understand their disabled children, and a baby sitting course. These classes are taught by professionals from RAFB. Services of the Chaplains and Red Cross are also available to families.

This assessment of the military and civilian environment confirms CARE's assumption that resources within the Randolph AFB area are decidedly limited. The limitations constitute a considerable constraint to the prevention, identification, and management of child abuse/neglect and child advocacy cases. This basic constraint is compounded by the tendency of both military and civilian communities to rely upon the major military medical installations and the metroplex of San Antonio for services. Therefore, it is doubtful that these constraints will be ameliorated in the foreseeable future. However, it is conceivable that existing resources may be better utilized in the identification and early assessment of cases. Improvements in the consistency of medical examinations and social work assessments performed at RAFB will facilitate the completion of assessments and the initiations of casemanagement in child abuse/neglect cases at the major medical complexes.

Effective coordination of services between bases does not occur spontaneously, but requires precise negotiations of roles, responsibilities, and reciprocity. Project CARE can make a significant contribution in this area, because of previous experiences in similar negotiations at BAMC and WHMC.

During the project's tenure at Randolph AFB, a number of systemic constraints have been identified. As previously stated, Randolph AFB is located near three different counties. Each of these counties has its

own individually administrated protective service unit. Therefore, the Child Advocacy Officer must coordinate and maintain a working relationship with several protective service workers from each of the three counties. Additionally, problems in reporting child abuse/neglect cases occur since a determination first must be made as to the appropriate unit to receive the report.

In addition to the constraints of limited civilian and military resources, and the reporting accountability to three separate county protective services units, there are significant discrepancies and inconsistancies in the several military directives to clinic personnel.

Prior to publication of AF Regulation 160-38, titled the Air Force Child Advocacy Program, Randolph AFB was operating under Wing Regulation 160-1. This regulation was a local supplement establishing responsibilities and procedures to be followed in cases of suspected child abuse. The local supplement is currently in the process of it's first revision since the Child Advocacy Program has been implemented. The new wing regulation describes Child Abuse, Child Abuse Patients and the Bexar County Child Welfare (BCCW) unit. The regulation provides general information from the Texas Family Code, Section 34.01, and sets out the responsibilities and procedures for reporting, patient transfer, warning of rights, recording of information and investigative responsibilities. In the wing regulation, the physician, or other person who suspected abuse or neglect, was directed to report the situation to BCCW. A similar report was to be made to the Security Police, Investigations Branch, and the Clinic Commander, the On-Call Chaplain, Operations Center, and the Staff Judge Advocate. Personnel rendering treatment were also advised to "make inquiry of the parent or guardian to determine the cause of injury, ..."

From 25 April 1975 until the present there have been three clinic directives. Clinic Regulation 160-38 became effective at Randolph AFB on 8 December 1975. The regulation defines the procedures for evaluation and disposition of infants and children with evidence suggestive of abuse or neglect who are brought to the Randolph AFB Clinic for treatment. The regulation contains specific criteria as to what may constitute physical abuse and neglect. Specific procedures are set forth for the medical evaluation and protection of suspected abused or neglect children. It states that the Child Advocacy Officer is to be advised of all cases; and that it is his responsibility to contact the BCCW office and report the incident, in compliance with state law.

The regulation further states that when a child is admitted to a hospital the attending physician shall prepare a statement to include pertinent history, physical findings, official x-ray interpretation, pertinent laboratory data, and opinions of consultants. The medical report is to be forwarded to the Director of Base Medical Services (DBMS) through the Child Advocacy Officer. The attending physician is also directed to arrange for an interview for the parents with the Mental Health Services at Randolph as soon as practical after admission of the child. The regulation further states that the CAC, which will meet at least quarterly, will provide follow-up of abuse/neglected children and their families.

All of these procedures are in accord with good medical practice, and in compliance with the Air Force Child Advocacy Regulation. However, the procedures cannot be fully implemented without negotiated interface between the Randolph Clinic as the referring base and WHMC and BAMC as the receiving bases. Although Air Force Regulation 160-38 sets forth procedures for all Air Force installations, specific local supplements, which include directives to other bases, must be negotiated and reciprocity agreed upon. There are many questions to be resolved in the assessment, remediation, and follow-up processes. Project CARE is in position to act as liaison with all military installations within the area, and has the capability to facilitate the necessary negotiations.

The SG directive of 17 December 1975 and the Acute Care Clinic procedures order of 5 January 1975, contain conflicting and confusing instructions for personnel providing direct care in cases of child abuse and neglect. While all of the directives have within them the core of good practice and compliance with the Air Force regulation, there needs to be a coordinated effort to develop a comprehensive Child Abuse/Neglect protocol.

Many environmental and systemic constraints have been identified in the five months since the project social worker has been assigned full time to RAFB. Compared to the experiences at BAMC and WHMC it is interesting to note that some of the basic constraints at RAFB are the reverse of those experienced at the other installations. For example, at RAFB specific medical services procedures have been developed and published in the form of Clinic Regulation 160-38. Additionally, there is a directive to personnel in the Acute Care Clinic on emergency referral to the BAMC emergency room, of cases of child abuse and child molestation cases. There is also a general staff directive to all health practitioners and clinic personnel providing "functional guidance for the evaluation and disposition of infants and children with evidence suggesting abuse or neglect." All of these procedures have been formulated without the benefit of formalized negotiation or agreement among the various disciplines and services at RAFB. It seems to be assumed that once the directives are circulated they will become internalized by departments and implemented by the designated personnel. It is even more significant that several of the procedures require the involvement of another Air Force Base or Army Post, and there is no evidence of viable interface between RAFB and the receiving hospital at WHMC or BAMC. The directives also seem to assume that the receiving installations will provide RAFB with collateral medical evaluations, and will arrange appointments for the parents to be interviewed at RAFB during the assessment and follow up phases of cases.

While the project is aware of the need for extensive negotiations of interface at RAFB, it would be impractical to attempt to initiate them until our own position at RAFB is clarified. Consequently, Project CARE's relationship with the CAO, the CPC, and the medical clinics are the first tasks to be confronted.

Negotiations for the assignment of a Project CARE worker to RAFB were initiated in September 1976. The first agreement called for the worker to

spend two days per week at the installation to receive referrals for intake/assessment and to participate in the Child Protection Committee (CPC) meetings. Negotiations were between the Project Director, the Director of Base Medical Services and the Chief of the Mental Health Clinic, a psychologist, designated as Child Advocacy Officer. In November 1976 further negotiations resulted in the first formalized coordination between the CAO and representatives from Guadalupe County Child Welfare (GCCW) and BCCW for joint participation in CPC meetings.

The focus of the first CPC meeting was on clarification of roles, priority of cases to be presented, and responsibilities of the CAO. It was decided that all referrals at RAFB would be made directly to the CAO, and that he would assume the responsibility for reporting the case to the appropriate protective service unit. The participants also agreed to staff problem cases with the parents of the child and committee members present. The CAO was also to report to other staff at Randolph, as designated by the wing regulation. Negotiations were confirmed for Project CARE to implement its social work procedures, and to act as liaison between the civilian communities and Randolph AFB. Provisions for office space, locked files, and telephone services for CARE were agreed upon.

During the months of December 1976 and January 1977, informal negotiations continued as the CARE worker provided services to families, however, the worker resigned from the project in early February to join the Air Force. The project coordinator at WHMC provided coverage for the cases assigned to the project until arrangements could be made for assignment of another project worker.

The second project social worker was assigned to RAFB in April 1977. After reassessment of the situation, it was agreed that better services could be provided if the worker was available full time. The original project worker, who had joined the Air Force, was assigned to RAFB and was the first social worker assigned as CAO to that base in compliance with the child advocacy regulation.

During April through July of 1977, the project received few referrals from the CAO. Negotiations and coordination of services to families were difficult to arrange since the CAO was in the process of adjustment to the new environment of the military and to his duties as CAO.

The first quarterly meeting of the Child Advocacy Committee (CAC) was held in July with adequate multidisciplinary representation. Child Protection Committee meetings have been held monthly and are attended by the CAO, CARE, and BCCW. Council participation by GCCW was disrupted for unknown reasons for several months. Rapport was reestablished with that unit by the CARE worker's written request for their continued participation. The unit supervisor directed the workers to resume participation on council meetings in August 1977.

In September 1977, the project will have been operative at RAFB for a year. During that year, only basic negotiations have been accomplished. These have included: Acquisition of an office and a telephone for CARE's

worker, agreement for the project to provide services to families utilizing the project's social work procedures, attendance by the project's social worker at monthly CPC and quarterly CAC meetings. There is a need for continuing negotiation if a modified service delivery system is to be implemented prior to CARE's termination.

Section 3

PREVENTION/EDUCATION SERVICES

Considerable evidence in the literature on child abuse and neglect has suggested that prevention must be part of any comprehensive program of services (Gil, 1970; Morgan, Gould & Matthews, 1964; Hurt, 1974). In addition, both the Army and Air Force regulations specifically address the necessity of prevention components in child advocacy programs.

During its first year, in keeping with the broad objectives of both Army and Air Force policies, Project CARE explored the areas of prevention conceptualized in the original project proposal. After the characteristics and needs of the Bexar County military population were thoroughly assessed, prevention and education programs were planned and implemented.

The accomplishments of the first year fell within three major categories: prevention through early identification, prevention through strengthened parenting skills, and prevention through provision of crisis child care.

Beginning in spring 1976, CARE conducted a variety of information seminars and training courses for such groups as physicians, hospital chaplains, intensive care and ward nurses, Army community health nurses, hospital ward and lab personnel, school personnel, and community groups. Subjects included were: potential factors leading to child abuse/neglect, identification of mothers and infants at risk, child advocacy regulations, relevant State laws, and the necessity for liaison with civilian agencies.

CARE's high visibility and ready access to a variety of military teaching facilities in Bexar County provided many opportunities for conducting various training modules. Therefore, plans were made to continue this task during the second year.

Prevention of child abuse through strengthened parenting skills was the objective of the following project accomplishments: A parenting education course for junior high school students, parenting education on the OB-GYN Ward, an adult parent effectiveness training course, and adult parenting education in a Well-Child Clinic setting.

The parenting class at the junior high school was well received, and negotiations began immediately for a second course during the 1977-78 school year. Parenting education was presented to more than eighty new mothers. The program was discontinued because the staff member conducting the course resigned from the project. Plans were made, however, to re-establish the module as soon as another staff member could assume the duty.

The adult parent effectiveness training (PET) course was sponsored by CARE on a one time basis only, due to time and staff constraints. PET classes are readily available in the community without need for CARE's involvement for other than referral.

CARE was invited by the Army community health nurses to participate in a Well-Child Screening Clinic for 3 to 4½ year olds. During the first year, CARE provided parenting instruction through the vehicle of creative play. In the second year, with a different CARE staff person, the focus changed from creative play to more of a parent's discussion group. When the nurses were unable to continue this clinic, due to lack of staff, CARE involvement also terminated.

Another preventive measure against child abuse and neglect undertaken by CARE was the provision of a program of crisis child care. Project CARE researched, planned, and initiated a varied program of alternative child care for use during familial stress situations. During the first year the project contracted with two military day care centers to provide crisis care on a short-term basis. Due to the success of the program, a third military day care center was contracted during the second year.

Another alternative for crisis child care evolved from CARE's search for a suitable twenty-four-hour crisis intervention facility. The project contracted to pay for short-term, inpatient psychiatric care for military dependent children; when referred by service providers who are qualified to assess their needs and to follow them upon discharge. Only children ineligible under any other public funding source qualify for this service. The program was implemented in July 1976 and has continued during the second year.

As a third alternative for crisis child care, CARE coordinated with the Texas State Department of Public Welfare and appropriate military representatives to recruit foster homes among military families. In support of the State program, CARE has publicized the need for military families as foster parents in the area's specialized military publications. As an extension of this task, a feature story on a military family serving as foster parents appeared in four publications distributed on military installations during the project's second year.

In the second year, in addition to redefining prevention and education needs, Project CARE has identified those individuals or services that could continue a prevention/education program following the project's termination.

Prevention and education programs initiated or continued during the second year were:

- Ongoing orientation for medical professionals
- Seminars for selected community groups
- Seminar for civilian and military law enforcement and legal personnel
- Seminar for day care staff
- Seminar for chaplains and representatives from community ministries
- Parenting education for adolescents

- o Parent education at screening clinic
- o Parenting education on Wilford Hall Medical Center (WHMC) OB-GYN Ward
- o Compilation of a curriculum manual
- o Organization and management of a speaker's bureau
- o Public information campaign
- o Short term psychiatric care
- o Volunteer services
- o Financial support for San Antonio Crisis Center Hot Line

Programs not implemented after extensive feasibility studies, not continued after preliminary trials, or completed with no further implementation planned during the second year were:

- o Courses on child abuse and neglect at Brooke Army Medical Center (BAMC) Clinical Specialist School and at Brooks AFB School of Aerospace Medicine
- o Presentations to junior and senior high schools at the military installations
- o Training for San Antonio Crisis Center Hot Line volunteers
- o Parenting effectiveness training

All of the implemented prevention/education programs were coordinated so a broad range of professionals, military families, and the community at large would be exposed to elements of this extensive network of programs for the prevention of child abuse/neglect and the promotion of family advocacy. The development, negotiations, implementation, and current status of each program after the end of the project's second year is described in the following narratives. Programs which were not implemented are also addressed in this section.

A successful program of services to abused and neglected children must be based upon continuing efforts at training professionals to recognize and respond appropriately to the subtle as well as the overt signs of abuse and neglect. Project CARE researched and identified groups most likely to become involved with families evidencing abusive and neglectful behavior. Educational programs suited to the special needs of each group were then planned. Medical, teaching, law enforcement, and day care personnel were among the target groups identified.

ONGOING ORIENTATION FOR MEDICAL PROFESSIONALS

Health professionals, such as physicians, nurses, and technicians are in an excellent position to identify, treat, and prevent further maltreatment of children. They are also in a position to detect stressful or dysfunctional family situations that could culminate in the abuse of a child.

Physicians

Physicians at Brooke Army Medical Center (BAMC) and at Wilford Hall Medical Center (WHMC) receive in-service training at regular intervals concerning child abuse and neglect. Efforts have continued to encourage the inclusion of a social worker in this training unit. The purpose of this is not only to increase the doctors' knowledge and awareness of child maltreatment, but also to facilitate the multidisciplinary team approach. Although no progress has been made in this area, the pediatric social worker at BAMC and the CARE social workers at BAMC, WHMC, and Randolph AFB are interacting frequently with the medical community; thus, educating them to the social worker's role and the team approach to child maltreatment.

Nurses

During the first year, nurses from several groups were instructed concerning child maltreatment, prevention, identification, reporting, and treatment. These groups were lectured again several times during the second year. Because the groups were composed of students, new personnel were involved during the second year presentations. The groups involved and the names of presentations in the second year were: Army community health nurses, in the Health and Environment Course at the Academy of Health Sciences; intensive care nurses, from BAMC Clinical Specialist School; and Air Force health nurses, from the Brooks AFB School of Aerospace Medicine. In addition, negotiations with the Chief of Nursing at BAMC resulted in two presentations to the nursing supervisors.

The Health and Environment Course at the Academy of Health Sciences and the Clinical Intensive Care Nurses Course at BAMC have permanently incorporated child abuse and neglect modules into their curriculums. As a result of CARE's involvement, and the great commitment of the course instructor, this has also been done at the only other Clinical Intensive Care Nursing Course; at Fitzsimmons Army Medical Center in Denver, Colorado. Project CARE's involvement with the health and environment course and the intensive care nursing course is no longer needed, as these groups are now self-sufficient and unable to use their community resources. The group of nurses from the Brooks AFB School of Aerospace Medicine were addressed on three occasions, during visits came to Fort Sam Houston for an orientation course taught by Army community health nurses. Because this course will no longer be taught by Army community health nurses, Project CARE's involvement will also terminate.

Academy of Health Sciences

The academy is a large teaching institution, where military officers and enlisted personnel from all branches of the Armed Forces are enrolled in a wide variety of health science courses. Many of these courses could appropriately incorporate a child abuse and neglect module. Examples of such courses include: Army Community Service Orientation; Chief Nurse Orientation; Clinical Pastoral Education; and Social Work/Psychology Procedures. Assessment of the environment and preliminary implementation activities began in April 1977 to incorporate child abuse and neglect modules into several courses now taught at the academy.

SCHOOL PERSONNEL

School personnel, particularly those in schools on the military installations, were identified as the second major target group for CARE's training efforts. Educators have daily contact with children; and their awareness of child abuse/neglect, child advocacy, and community resources was recognized as a necessity. In addition, the Texas and military laws relating to the schools needed exploration.

Presentations, negotiated with school administrators during the first year, were implemented and completed during the second year at Kelly AFB, Lackland AFB, Randolph AFB and Fort Sam Houston; as well as at one civilian school with a large military enrollment, Southside Independent School District.

COMMUNITY GROUPS

Numerous presentations of various kinds have been conducted for both military and civilian groups during the two years of the project. The following are examples of presentations during the second year:

- Orientation on child abuse to a church group in a community adjoining Fort Sam Houston
- Presentation to military management personnel at Kelly AFB on Project CARE, the Air Force child advocacy regulation, and identification and reporting of child abuse.
- Participation in a seminar at Fort Polk, Louisiana, to share the objectives of Project CARE for military-wide implementation of a comprehensive child advocacy program.
- Orientation of a psychology class at a local university concerning the military child abuse program.
- Orientation on CARE and the child advocacy program to a chaplain's assistance committee at Lackland AFB.
- Participation in two panel presentations at a national conference on child abuse and neglect

- o Orientation on child abuse and the Army child advocacy program for new volunteers of the Army Community Service volunteer program

PARENTING EDUCATION

Inadequate parenting education encourages young parents to develop inappropriate expectations of their children. Many new parents can be heavily influenced by the unrealistic view of parenting presented in the visual media, magazine articles, and advertisements. Inadequate parenting skills frequently can be related to societal rather than individual failure. In pursuit of the goal of strengthening family life; Project CARE developed and implemented, during the past two years, several modules of parenting education to serve as tools for the primary prevention of child abuse and neglect. The modules developed were: parenting education for adolescents at the junior high school level, parenting education for first time mothers on the OB ward, a parent effectiveness training class for the military community, parent counseling at a well-child screening clinic; and dissemination of parenting material to new parents.

Parenting Education for Adolescents

Family life education in public school systems has been cited as a key component in a comprehensive program of child abuse prevention (Gil, 1970). Therefore, a program of parenting education for adolescents was developed by CARE as a major effort to strengthen parenting skills through classroom study and field training. The negotiations for this program with Cole High School, Fort Sam Houston Elementary School, and Fort Sam Houston Child Care Center took place during the first year of the project. Implementation began in September 1976.

Following consideration of age, sex, and grade level an existing homemaking class of eight grade boys and girls was selected as ideal for the pilot testing. Classes were held twice weekly and consisted of fifty-five minutes of classroom instruction. The sixteen sessions were divided into pre-test (1), post-test (1), child growth and development (2), child abuse/neglect (1), planning and discussion (3), and visits to child care center (8).

Because there is no substitute for direct experience with children, student involvement at the child care center and at a kindergarten class was planned. Some students had previous experience interacting with young children in their own families; however, the laboratory setting served as a valuable teaching tool, providing students with a structured learning situation to augment past experience and prepare for the future.

Prior to the field visits, class planning sessions and discussions were held. Several sessions were devoted to child growth and development. Selected materials were used from the model curriculum Exploring Childhood, developed by the Education Development Center of Cambridge, Massachusetts, as a result of funding from the Office of Child Development (OCD) and the National Institute of Mental Health. Films from Planned Parenthood of San Antonio and Perennial Education of Northfield, Illinois were also used. An

assistant professor of nursing and a pediatric nurse practitioner taught the segments on child growth and development. The session on child abuse and neglect was taught by CARE staff members.

The students and the teacher evaluated the course. A post-test was administered to students at the final session to measure changes in knowledge level or attitudes following exposure to the parenting module.

The module generated much interest from school administrators and an attempt was made to incorporate a parenting module permanently into the curriculum. This did not prove feasible at this time; however, now that school administrators are more aware of the need for parenting education they are seeking ways to implement such a program. The parenting curriculum prepared and tested by CARE will be of value in setting up such a program.

Parenting Education on OB Ward at WHMC

A second program of parenting education was begun at Wilford Hall Medical Center in September 1976. WHMC provides expectant parent classes every two months. These classes are optional, and are offered by medical professionals from the departments of obstetrics, dietetics, physical therapy, and pediatrics. Four consecutive weekly sessions are presented to each class on such topics as : diet in pregnancy; psychotherapy, pregnancy and labor delivery; obstetrical anesthesia; and care of the newborn.

The hospital staff observed that the first three sessions are well attended, but that there is a marked decrease in attendance at the fourth session, care of the newborn. This decrease was attributed to the lack of immediate need for this information prior to birth since parents may participate in this class any time.

The obstetrical service has a very small staff and is unable to provide any additional teaching services on the ward. Rooming-in is available on the OB Ward, for mothers to care for their infants during the day, and the nursing staff is kept busy with patients and newborns. A volunteer offers the only educational component, one day a week instruction in breast feeding, provided on the ward itself.

The child advocacy officer, chief child psychiatrist, and several pediatricians discussed the possibility of offering a class (an extension of the expectant parent class) primarily for parents of infants six to eight weeks old, but open to any interested parents. This class would emphasize child development and nonviolent punishment.

After discussion by the WHMC Project CARE staff coordinator, the child protection committee chairman and the OB nursing supervisor agreed that there was a definite need for instruction on the ward, prior to the mother's release from the hospital. Acknowledging that the neonatal period is a crucial time for both mother and infant, and that their interaction at this time may set a pattern that will continue throughout childhood, it was concluded that intervention was appropriate and necessary.

Permission was obtained to implement a module of instruction for first-time mothers, but open to anyone wishing to participate. This module was presented twice weekly, with the goal of enhancing early infant care and preventing child abuse and neglect. The instruction was designed to develop awareness in the mother of her responsibilities to her child and to stimulate desire for additional parenting knowledge. After its conclusion, this course was found to be very effective; not only in disseminating information but also in identifying potential problem situations.

Parent Effectiveness Training (PET)

As a third program for strengthening parenting skills through experiential learning, Project CARE offered a course in parent effectiveness training in September 1976. Parenting effectiveness training was developed in 1962 by Dr. Thomas Gordon. Dr. Gordon felt that through PET parents could be trained to develop effective relationships and improve communications with their children. He also felt PET could help parents, already experiencing difficulty, cope more effectively with problems.

Project CARE visualized an additional dimension to PET--child abuse/neglect prevention for parents who might themselves have been victims of maladaptive child rearing patterns, and who would tend to transmit such experiences to a new generation. The availability of PET at Bexar County military installations was explored with BAMC Social Work Service, Army Community Services (ACS), and Special Services. Classes were already being offered at Randolph AFB and WHMC, but none at Fort Sam Houston. CARE sought and located a highly qualified instructor already involved in teaching a PET class at WHMC and approval for this instructor to teach an additional course at Fort Sam Houston was obtained from the chairman of the Mental Health Department, WHMC.

To stimulate interest in the class, articles were included in the daily bulletins of BAMC, the Academy of Health Sciences, and Fort Sam Houston. A sign-up sheet for the course was also placed in the registration area of the Third Annual San Antonio Child Abuse Conference. The class was open to active duty and retired military personnel, dependents, and DOD civilians. When interest in PET was established, telephone contact was made with registrants and classes scheduled. Twenty-two students attended the eight week course's three-hour weekly sessions.

Although much interest was expressed in a second course, CARE was unable to comply due to staff time limits. PET courses are frequently offered in both the military and civilian communities and are readily available. CARE's initial involvement in PET was to test the inclusion of a child abuse/neglect segment. The segment worked well and can be duplicated in any PET class. A basic prerequisite is the availability of an instructor knowledgeable about child abuse and neglect.

Parent Counseling at a Well-Child Screening Clinic

CARE participated in a well-child screening clinic sponsored by BAMC's community health nurses. The clinic gave the children, 3 to 4½ years of age, health and development screening; and their parents a short group

session. The session, facilitated by a CARE staff member, explored viable parenting methods through the medium of creative play. While presenting creative play ideas; the CARE member discussed proper discipline, nutrition, diet, sleep habits, and parent-child relationships. Because the session was short--about twenty minutes--it was difficult to cover topics sufficiently. The parents were eager to share and had many questions.

When a different CARE staff member assumed this task, the creative play section was eliminated to allow time for more interaction between the parents. The CARE group facilitator encouraged the parents to help answer each other's questions. Pamphlets acquired from Metropolitan Life Insurance Company on topics such as: discipline, toilet training, fear of the dark, and nutrition were distributed to each parent. Information on resources was offered, and often enthusiastically received. Most participating parents expressed positive feelings about the group and many parents stated that such a group was essential, because of the many stresses experienced by military families. The clinic was discontinued by the Army community health nurses, due to staff constraints, and CARE's involvement terminated. CARE recommends some type of parent group for military communities. For example, at Fort Sam Houston, the Army Community Service Volunteers or a chaplain could sponsor a group.

Dissemination of Parenting Literature

As another element of its broad program of parenting education, Project CARE explored methods of providing such education to the large number of maternity patients at BAMC and WHMC. CARE quickly learned of Pierre the Texas Pelican, a series of twenty-eight newsletters about child growth and development from birth until age six.

After acquiring the materials from the Texas Department of Community Affairs, CARE coordinated its efforts with the Army community health nurses. Distribution efforts began in April 1976 and have continued throughout CARE's second year. In addition to distribution at postpartum and newborn classes, the newsletter was also disseminated to parents at the well-child screening clinic previously mentioned.

CURRICULUM MANUAL

An assessment of the environment disclosed the need for a continuing program of education in child abuse and neglect. Project CARE staff developed and delivered various presentations for such groups as: medical personnel, educators, first-time parents, child care workers, and adolescents. One of CARE's criteria for each innovation has been that it be designed for continuation by personnel normally in the environment. During the second year, in order to meet this criterion, a manual was begun which will incorporate all the educational modules designed by CARE.

The manual will be a resource for trainers, or other persons providing education on child abuse and neglect. In addition to presentation information, the manual will also contain a bibliography and recommendations on facilitating an effective program.

PUBLIC INFORMATION CAMPAIGN

Project CARE's public information effort has been designed to limit its impact primarily to its target audience--the San Antonio military community. For this reason the electronic media has been generally avoided, since excessive exposure of the civilian community to material about child abuse in the military might lead to misconceptions and subsequent military hypersensitivity about the subject.

By utilizing printed media such as posters, pamphlets, and military oriented newspapers, CARE has reached its desired audience with messages about its programs. Pamphlets and posters used in support of CARE programs included both DPW material and CARE designed material.

Reprints of sections of CARE reports and documents were used also in answering the high volume of inquiries from universities, social work agencies, and interested citizens.

SPEAKER'S BUREAU

In its continuing effort to educate the community on child abuse and neglect, and demonstrateeffective methods of coordination with civilian agencies; CARE, during its second year, organized the San Antonio Child Abuse Speaker's Bureau. Through letters and direct contact, forty-four persons (including two CARE members) were recruited to participate in the bureau. Requests for presentations, from any source, are received and coordinated by a CARE staff member. The military is represented by only four members; however, the child advocacy officers and the members of the child advocacy committees are usually available for presentations. Additional recruiting efforts will be made during the third year.

SEMINARS

In addition to the previously discussed educational programs, seminars for community groups, for civilian and military law enforcement personnel, and for child care center personnel were also initiated by CARE in 1977. The seminars focused on advocacy with military families and on an orientation to referral resources. The structure and schedule of these presentations is detailed in a following section.

The prevention efforts of the project have been varied to demonstrate the alternatives available for the prevention and identification of child abuse and neglect. CARE's preventive programs during the project's second year were: crisis child care, foster home recruitment, short-term psychiatric care, volunteer services, and expansion of a "Hot Line" referral system.

CRISIS CHILD CARE

A major program established by the project as a preventive measure was the provision of crisis child care. Crisis care has been conceptualized as

"a safe place in each community where, on the decision of the mother alone, and with no delay or red tape, the child could be recieved for a few hours or a few weeks" (Kempe, 1971). Schneider (1974) described using day care centers and twenty-four hour crisis nurseries as facilities to remove stress from the mother when she feels in a crisis, or needs a way to experience some freedom from the constant responsibilities of child caring. Even minimal intervention seems to prevent physical abuse to the child. In describing the involvement of families in an innovative project providing combination day care and counseling, Bean (1975) reported that parents could change if given the opportunity and if certain environmental resources were provided. For a mother under stress to have an adequate place to leave her children for a few hours may mean the difference between finding the relief she needs and abusing her child.

With the need to provide crisis care for families firmly established, CARE explored the possibility of providing twenty-four hour nursery care for children of military families at Fort Sam Houston, Lackland AFB, and Randolph AFB. While all the child care centers approached were receptive to the idea of twenty-four hour care, the cost proved to be prohibitive. After exploring various alternatives, it was decided to provide crisis care at the centers during normal operating hours only.

In July 1976, contracts to provide crisis care were finalized with Fort Sam Houston Child Care Center and Lackland AFB Child Care Center. Early in 1977, a similar contract was signed with the Randolph AFB Child Care Center.

Guidelines for use of the centers were devised and distributed to potential users, such as BCCW and permanent members of the installation child advocacy councils. A tracking methods was also developed to collect data on such variables as reason for placement; referral agency; name, age, and sex of child; military status of parent; hours used; and total cost. These data have been used for periodic assessments of the impact of this project component (see table 3.1). Although the table can give an account of utilization, the number of repeat referrals from the same service providers provides a more accurate picture of the need for and value of the program.

FOSTER HOME RECRUITMENT

The removal of a child from his home is sometimes necessary during crisis intervention and child protection efforts. When parents reach the point of feeling overwhelmed and exhausted by their children, they are in a potentially abusive situation. Foster care, even for short relief periods, can be a "saving factor" for both parents and children in such cases (Alexander, 1972). CARE planned to explore and coordinate this activity with the foster home recruitment and licensing unit of the Texas State Department of Public Welfare and military representatives. A plan for CARE assisted funding of foster homes on the military installations proved to be unfeasible. As an alternative, CARE coordinated with the State Department of Public Welfare and military representatives to recruit foster homes among military families. In support of the State program,

Table 3.1. Child Care Centers
Annual Report
1976

	Jul.	Aug.	Sept.	Oct.	Nov.	Dec.	1976 1st 6 Month Totals
1. Number of Children	3	4	9	2	4	10	32
2. Number of Days	4	4	5	2	4	9	28
3. Number of Hours	17	50	67	47	15	40	236
4. Age Ranges							
3 mos - 1 yr	1	2	4	1	2	1	11
2 yrs - 3 yrs	1	2	4	1	1	7	16
4 yrs - 5 yrs	1	-	1	-	1	2	5
6 yrs - 7 yrs	-	-	-	-	-	-	-
8 yrs - 9 yrs	-	-	-	-	-	-	-
10 yrs	-	-	-	-	-	-	-
5. Sex							
Male	3	2	6	1	2	5	19
Female	-	2	3	1	2	5	13
6. Sponser's Military Status							
Active Army	2	4	7	2	3	-	18
Retired Army	-	-	-	-	-	-	-
Active Air Force	-	-	2	-	1	10	13
Retired Air Force	2	-	-	-	-	-	2
Other	-	-	-	-	-	-	-
7. Total Cost	17.55	42.85	52.75	39.95	14.75	40.50	208.35

Table 3.1. Child Care Centers--Continued
Annual Report
1976

	Jul.	Aug.	Sept.	Oct.	Nov.	Dec.	1976 1st 6 Month Totals
8. Reason for Placement							
Counseling and Medical Appointments	2	-	2	-	2	10	16
"Time Out" to Alleviate Stress	-	4	4	-	2	-	10
Time to Plan or Arrange Improved Home Situation	1	-	3	2	-	-	6
9. Number of Children Referred by Each Agency							
BCCW	1	-	2	2	-	-	5
CARE	1	-	-	-	-	-	1
BAMC Social Work	1	4	5	-	3	-	13
CAO-Ft. Sam	-	-	-	-	-	-	-
CAO-Lackland	-	-	2	-	1	9	12
Child and Adolescent Guidance Clinic-Lackland	-	-	-	-	-	1	1
CAO-Randolph	-	-	-	-	-	-	-
CAO-Brooks	-	-	-	-	-	-	-
CAO-Kelly	-	-	-	-	-	-	-

Table 3.1. Child Care Centers
Annual Report
1977

	Jan.	Feb.	Mar.	April	May	June	1977 2nd 6 months Totals	12 months Total
1. Number of Children	15	16	15	18	11	14	89	121
2. Number of Days	33	39	28	27	17	11	55	83
3. Number of Hours	222	232	230	198	100	146	1,028	1,264
4. Age Ranges								
3 mos - 1 yr.	3	4	4	2	3	3	19	30
2 yrs - 3 yrs	8	6	5	6	4	5	34	50
4 yrs - 5 yrs	4	5	5	5	5	2	26	31
6 yrs - 7 yrs	-	-	1	5	-	3	9	9
8 yrs - 9 yrs	-	1	-	-	-	-	1	1
10 yrs	-	-	-	-	-	-	-	-
5. Sex								
Male	7	9	7	11	6	8	48	67
Female	8	7	8	7	5	6	41	54
6. Sponser's Military Status								
Active Army	6	7	5	8	6	7	39	57
Retired Army	-	-	-	-	-	-	-	-
Active Air Force	9	9	10	10	5	7	50	63
Retired Air Force	-	-	-	-	-	-	-	2

Table 3.1. Child Care Centers--Continued
Annual Report
1977

	Jan.	Feb.	Mar.	April	May	June	1977 2nd 6 months Totals	12 months Total
7. Total Cost	251.95	274.25	197.65	251.60	127.60	59.15	1,161.20	1,369.55
8. Reason for Placement								
o Counseling and Medical Appointments			3	6	4	7	20	36
o "Time Out" to Alleviate Stress	15	16	12	12	7	5	67	70
o Time to Plan or Arrange Improved Home Situation	-	-	-	-	-	2	2	8
9. Number of Children Referred by Each Agency								
o BCCW	-	-	1	3	-	-	4	9
o CARE	4	3	4	7	6	3	27	28
o BAMC Social Work	2	4	1	-	-	4	11	24
o CAO Ft. Sam	-	-	-	-	-	-	-	-
o CAO Lackland	8	8	8	7	4	6	41	53
o Child & Guidance Clinic, Lackland	1	1	1	-	-	-	3	4
o CAO-Randolph	-	-	-	1	1	1	3	3
o CAO-Brooks		-	-	-	-	-	-	-
o CAO-Kelly	-	-	-	-	-	-	-	-

CARE has: disseminated recruitment literature through Army Community Services at Fort Sam Houston and Fort Sam Houston library system; assisted the State recruitment worker in identifying and contacting persons and agencies who can participate in recruitment; and publicized the need for military families as foster parents in the area's specialized military publications.

SHORT-TERM PSYCHIATRIC CARE

Plans to contract for short-term residential psychiatric care evolved from CARE's search for a suitable twenty-four hour crisis intervention facility. In addition, a need for referral resources for teenagers at Fort Sam Houston had been expressed by the Provost Marshal at a meeting of service providers to consider the increasing problem of unsupervised teenagers roaming the post at night.

After a careful review of the programs offered at the San Antonio Children's Center, CARE determined it to be an appropriate resource for children needing short-term residential psychiatric treatment. A contract was quickly negotiated for this second crisis child care alternative. Project CARE contracted to pay for short-term inpatient care for military dependent children, referred by service providers qualified to assess their needs and to follow them after discharge. Only children ineligible under other funding sources qualify under this contract.

The program was implemented in July 1976 and, to date, only one child has used this facility. The availability of CHAMPUS funding for military sponsors and dependents may be a decisive factor in the low utilization of this resource.

VOLUNTEER SERVICES

When Project CARE was originally conceptualized, a volunteer program was suggested as a means of meeting the needs of crisis child care and emergency transportation. During CARE's planning period other functions were considered, including friendly visits to incoming families; medical outreach to new mothers; secretarial support; telephone outreach to new mothers, and families who are separated from relatives or close friends.

Several sources of volunteers were available. An existing volunteer group at Fort Sam Houston's Army Community Services (ACS) expressed interest in working with CARE. In addition, DPW region IX has an extensive volunteer program with a full-time coordinator of volunteer services.

In studying the feasibility of establishing a volunteer program several factors were considered. Involving volunteers in meaningful activity, and mutual agreement regarding its nature, was defined as basic to the program. The need for involving volunteers quickly after selection and training was also recognized as important. An additional consideration was the availability of staff for supervision of volunteer training and utilization. After lengthy evaluation, development of a volunteer program to meet the two orginally conceptualized needs was determined to be unfeasible.

Because the existing volunteer group at Fort Sam Houston's Army Community Services was eager to become involved, and because of CARE's limited need for volunteer involvement, an alternative was considered. CARE offered to facilitate the ACS volunteers' involvement with region IX's volunteer program to make volunteers available for military clients of DPW. In addition, during the second year, efforts were made to obtain volunteers to assist in the military-based child care centers. A representative from region IX's volunteer program was invited by CARE to attend a meeting of the child care center directors. The volunteer program was explained and the directors were encouraged to request volunteers through the Region's office.

EXPANSION OF HOT LINE REFERRAL SERVICES

Community resources which respond immediately to a family crisis support the concept of prevention through early identification and intervention. In order to facilitate efficient, effective response to the needs of military families; Project CARE has planned and implemented orientation and training sessions, referral coordination, and financial support for the San Antonio Crisis Center. The child abuse hot line of San Antonio Crisis Center offers a twenty-four hour telephone crisis intervention and information service, handling calls from residents of the San Antonio metropolitan area. This service was established to offer assistance to individuals concerned about child abuse or difficult child management situations. An innovative service of the crisis center is a direct telephone patch facility. Through this system referrals can be greatly facilitated by patching calls directly into recommended treatment resources.

Negotiations and coordination of orientation and training sessions for crisis center volunteers began in June 1976. Orientation sessions focused on stresses common to military life and on the military and community resources available to help families deal with these stresses. A comprehensive and up-to-date listing of the child abuse/neglect resources at the five military installations and in the community was provided and procedures for referrals were also reviewed.

In addition to providing orientation information, Project CARE has made a commitment to provide an annual grant equal to 1/3 of 20 percent (the percentage of San Antonio's military population) of the crisis center's yearly operating costs. The grants for the first and second year have been made.

During the second year, Project CARE has been receiving reports from the hot line director indicating the number and type of child abuse and neglect referrals received per month. At the end of June, the 1977 total for calls received was 238. The nature of the calls varied from requests for information for term papers to reports of beatings occurring at that moment. On the average only two calls a month were patched through to other agencies. Generally, the informant was given a resource telephone number to call. More than 3/4 of the informants were referred to Bexar County Child Welfare (BCCW). In checking with BCCW, to determine if the

informant followed up on the referral, it was found that only two or three callers each month stated they were referred through the crisis line. Because many of those referred may not disclose that they were referred through the crisis hot line, it is impossible to determine exactly how many callers referred actually follow through. Possibly if the hot line would patch-through calls more frequently, and if BCCW point-of-entry workers would inquire if the party was referred from another agency, a more accurate picture could be drawn. It is alarming to think that some serious cases may not be referred because informants get tired of calling more than one agency.

PROJECTIONS

In summary, in the broad area of prevention of child abuse and neglect and the advancement of child advocacy, Project CARE has not only met its original commitment but has far surpassed it in responding to the widespread need for services. During the project's first two years, an extensive program of prevention through early identification, strengthened parenting skills, and provision of crisis child care has been developed and implemented. Many of these components are designed to facilitate their continuation during and beyond the third and final year of the project. A long-range impact upon preventive and educational services for military families and children is therefore anticipated.

Increased negotiations with the Academy of Health Sciences are planned in order to augment as many of the AHS course curriculums as possible with child abuse and neglect modules. This will be difficult since the inclusion of new material is often resisted, since some current material may have to be deleted to allow time for the child abuse module. The enormous value of the accomplishment of this task is apparent when the large number of students affected, and their world-wide distribution upon completion of their studies, is considered.

Army community health nurses have long been the experts in the child abuse and neglect field within their environment. During CARE's third year their aid will continue to be sought in finding new areas of education in child abuse and neglect for all nurses. With the Army community health nurses' further assistance, CARE will negotiate with the BAMC nursing supervisors to expand upon the first two presentations given during the second year.

Negotiations for Project CARE services to the OB ward for the third and final year are currently underway. The parenting course has been eliminated and liaison with OB will encompass a new dimension. It has been planned that the liaison member will be available to the ward as a consultant and will provide consultation on high risk medical and social situations which could develop into child abuse/neglect or child advocacy cases. She will make social service referrals and provide casework services in crisis situations.

The project will continue to provide funds and supervision for the crisis child care program during the third year; however, efforts will be made to locate a funding source for the continuation of this program after

the project ends. The Child Advocacy Council will be encouraged to assume leadership in this endeavor. The contract for psychiatric care will continue in order to fully assess the need for this type of program.

Continued participation in the recruitment of foster homes is anticipated, as the great need for homes continues. The project will also utilize volunteers wherever feasible.

There have been difficulties because the Crisis Center and Bexar County Child Welfare have been unable to solve the referral question. Project CARE will assist in attempting to remedy this problem.

The curriculum manual, begun during the second year, is scheduled for completion in the fall of 1977. The manual will be disseminated to child advocacy officers and others in the military community with CA/N training responsibilities.

During the thrid year, CARE is considering the testing of a much shorter parenting module with a senior high school class. The four-day module developed and used by the Child Abuse and Neglect Demonstration Organization Project, funded by the Office of Child Development, Department of Health, Education and Welfare (Grant No. 90-C-395 /C1/), is being considered as a model for the new program. A shorter module, tested with a different age group, would give CARE and school administrators a better basis for choosing the most effective parenting program.

Since an aware community is the best assurance of an effective child advocacy program, presentations to the military and civilian community will continue during the project's third year, through the staff's involvement in the speaker's bureau of the San Antonio Child Abuse Council. The speaker's bureau will be advertised in both the civilian and military communities. All requests to CARE for further education of community groups will be coordinated through the speaker's bureau.

Requests from schools for presentations will be handled through the child advocacy councils, as they are mandated to educate and train personnel to prevent child abuse and neglect. Involvement of the councils, through the child advocacy officer, will not only provide a comprehensive presentation on the military child advocacy program but will facilitate the continuation of this educational component beyond the remaining year of the project.

Section 4

SOCIAL POLICY STUDY

One of the five program objectives in Project CARE's original proposal to HEW included the undertaking of a social policy study of military child advocacy in San Antonio, Texas. In early 1977, Project CARE employed an individual from DPW's Special Projects Bureau to develop a study design.

CARE's proposal contained a reference to sociologist David Gil of Brandeis University; specifically, that the study would be based on Gil's model for policy analysis. Consequently, one of the first tasks related to the study design was to review Gil's work and to recommend a plan for its use.

The major activity undertaken during the project's second year has been the design of the study. Meetings were initiated with concerned organizations (i.e. Texas State Department of Public Welfare's state and regional offices, Brooke Army Medical Center, Wilford Hall Air Force Medical Center, Office of the Surgeon General, and National Center on Child Abuse and Neglect) to discuss the objectives of the study, the specific information needs of each representative, and desirable areas for policy recommendations. An additional purpose of the meetings was to determine the status of child abuse and neglect programs and any priorities, changes, or plans in this program area within each organization.

Project CARE prepared a preliminary work program for these organizations as a basis of discussion and as a guide to the development of the study design. The series of meetings were useful in pinpointing special areas of interest and concern. The meeting also provided the opportunity to determine how each organization might potentially use the study report to strengthen their child abuse and neglect efforts. The results of the discussion meetings can be summarized as follows:

- DPW state and regional office representatives expressed interest in study findings which contribute to the resolution of case management problems, particularly in the legal and jurisdictional area. Additionally, interest was expressed regarding the military community's attitude toward child neglect, as opposed to child abuse

- Office of the Surgeon General representatives expressed interest in survey information from child advocacy officers and installation councils and teams on the strengths and weaknesses of the military community's efforts

- The National Center on Child Abuse and Neglect representative expressed interest in general knowledge regarding the level of activity of military child abuse and neglect efforts and areas of special concern

Project CARE's social policy study of military child advocacy efforts examines the efforts of the military community to enhance their capacity to reduce incidents of child abuse and neglect; in particular, through the establishment and implementation of the military child advocacy program.

The major area examined in the study is the development of collaborative relationships between state and county child welfare agencies and military resources. Specifically, the policy study identifies and analyzes the problems and barriers to achievement of child advocacy program objectives.

The two main objectives to the social policy study are as follows:

- o Identification and analysis of barriers to implementation of the child advocacy program in San Antonio, Texas

- o Development and dissemination of recommendations to reduce and prevent legal, jurisdictional, and administrative constraints which affect the abilities of child advocacy officers, child welfare personnel, and other military and civilian persons to provide prevention and treatment services to troubled families

The findings of the study are being prepared in the form of a study report. The report document contains the following sections:

SECTION A: PERSPECTIVE OF MILITARY CHILD ABUSE PROGRAMS

This section contains a historical overview of child protective services in the military community and the evolution of child advocacy programs. The sections includes: an analysis of federal laws and events which influenced the design and implementation of military services to troubled families; a summary analysis of military policies and regulations affecting child and family advocacy; a discussion of the extent of which the objectives of the 1974 Act and military child advocacy regulations are in congruence and/or in conflict with each other; the extent to which the value premises underlying military child advocacy are in congruence with our society's dominant value premises; and, discussion of the compatability of military child advocacy strategies with the social theories that explain the causes and dynamics of child abuse and neglect.

SECTION B. MILITARY CHILD ADVOCACY IN SAN ANTONIO, TEXAS

This section describes and analyzes the interaction among Project CARE, Bexar County Child Welfare, and the two major military medical facilities (Brooke Army Medical Center and Wilford Hall Air Force Medical Center) to achieve the intent of the child advocacy program. Specifically, this section examines the operational barriers experienced by military and civilian personnel involved in child welfare and child protection services to military families.

SECTION C: RECOMMENDATIONS

Based on an analysis of a literature survey, a survey questionnaire of military child advocacy council and child protection case management team members, and Texas child welfare personnel, recommendations will be made to facilitate the achievement of child advocacy program objectives. Specific recommendations for dealing with each problem area examined will be presented for possible utilization by other states and at other installations. These "guidelines for action" will offer designated military child advocacy officers, military and civilian administrators, and direct services personnel, principles for working collaboratively to assist troubled military families.

Developmental work on the study design involved a review of federal and State legislation and military regulations related to child abuse and neglect. This included a summary review of six federal acts, nine military regulations and two State laws. Child abuse and neglect literature was reviewed, particularly articles written by military professionals, to trace the evolution of child protective services in the Armed Forces.

Texts written on the subject of social planning and change were reviewed to identify practical approaches to conducting a social policy study. Due to the variety of interpretations of a social policy study, no single theory or approach was broad enough to address the areas to be examined. Consequently, approaches from several other authors will be incorporated with Gil's policy model, in the study design.

Finally, Project CARE materials related to planning research and service operations were reviewed for relevancy to the policy study. Discussion meetings with Project CARE operations staff were useful in pinpointing problem areas arising when military and civilian agencies provide services to military families. This resulted in the identification of possible items to be examined in the study. Meetings with research staff were also useful, particularly since research questions being examined in a 200 case sample led to the development of related questions for inclusion in a proposed survey questionnaire for personnel at other Texas military installations. In other words, select problem areas related to case identification, reporting, assessment, and treatment services were identified and may be common to a large number of installations. This will be explored through the survey.

Following the literature review and preparation of a preliminary work program, planning meetings were held with DPW administrative staff who are responsible for the provision of child welfare and child protection services. Their input, early in the study design, was requested in the following areas: Level of interest in study findings; interest in participating in the study through interviews, questionnaires, and review of study materials; and concern with particular topics relevant to local child welfare staff work with troubled military families.

- o Level of interest in study findings -- DPW is interested in study findings because of a commitment to continually improve its protective services to Texas citizens. Additionally, the study has

heightened the department's awareness of the special needs of working with troubled military families and the unique aspects of providing child welfare services to this client group

- o Interest in participating in the study -- The DPW regional office staff expressed high interest in participation and offered staff assistance as respondents to both the interviews and questionnaires. Additionally, administrative staff offered their assistance in reviewing pertinent materials prepared as part of the study.

  During the review of the proposed military questionnaire, DPW staff suggested a similar questionnaire be administered to child welfare personnel, located throughout the State, who have substantial numbers of military families as clients. This idea was accepted since it provides an additional perspective to the study of the child advocacy program. Consequently, work sessions have been held with staff of DPW's Social Services Branch at the State office level and child welfare personnel at the county level to prepare and revise a survey instrument for child welfare.

- o Topics relevant to child welfare -- Most important, child welfare staff views the study as an opportunity to examine a number of topic areas related to case management, particularly of a legal and jurisdictional nature.

Both the survey instruments for child welfare staff and military child advocacy personnel will be pretested in September 1977. Contacts have been initiated with representatives of two DPW regions to discuss their interest in participating in the pretest. These two regions have been selected because both serve substantial numbers of military families and have a special interest in working with the military community on the problems of child abuse and neglect.

The pretest of the questionnaire will be administered to approximately three or four child welfare staff members and an equal number of military personnel. Following an on-site analysis of the responses, interviews will be held with pretest participants to identify questions which were unclear or misinterpreted, and to get an overall attitudinal response toward the instrument from each respondent. Modifications to existing questions will be made in order to achieve greater clarity and to insure that the questionnaire can be completed by respondents in less than thirty minutes. Following modification of the questionnaire, arrangements will be made for its administration during October 1977 at all sixteen Texas military installations and in the DPW regions in which those installations are located.

All members of Air Force child advocacy committees or Army child protection case management teams at these installations will be requested to complete the questionnaire; all child welfare staff (i.e. program directors, supervisors, and caseworkers) who have substantial numbers of military families in their protective services caseloads will also complete the questionnaire. The respondents represent a wide range of professional disciplines, and will offer varying perspectives toward their involvement in the military child advocacy program. The findings are intended to

provide these same individuals with information useful in carrying out their responsibilities as committee or team members.

After the collection of the questionnaires, the data will be analyzed in November 1977 and the finding prepared for inclusion in the study report document in January 1978. Additionally, a formal video presentation will be prepared for several audiences, including representatives of the Surgeon General's Office in Washington, D.C., DPW state and region offices, and the National Center on Child Abuse and Neglect. If staff and time resources permit; a special workshop may be provided, in cooperation with the Surgeon General's Office and DPW Social Services Branch, for military child advocacy program officers and child welfare staff to present the findings of the research effort and the recommendations developed from the social policy study.

Additionally, Project CARE staff will collaborate with DPW's Legal Services Branch and the Social Services Branch in the development of any desirable materials which contribute to improved policies or procedures.

Copies of the study report document will be made available to the National Center on Child Abuse and Neglect, Surgeon General's Office, and to DPW state and regional office personnel whose responsibilities are related to the problems of child maltreatment. Copies will also be provided, upon request, to all interested public and private groups, as available.

Project CARE staff will be prepared to present a session on the social policy study findings at the Annual San Antonio Child Abuse Conference (1977) and the Third Annual National Conference on Child Abuse and Neglect (1978).

In June 1977, Project CARE's federal project officer made an on-site visit to San Antonio and met with the staff on a number of related subjects. The discussion included the status of the development of national standards for the prevention, identification, and treatment of child abuse and neglect.

Project CARE was informed of the following: the commitment of the National Center on Child Abuse and Neglect (NCCAN) to develop such standards for the Armed Forces; the comments on the preliminary draft of standards received from persons and organizations across the country on the need to have guidelines which address the military population; that the NCCAN contract with the National Institute of Advanced Studies (NIAS) to develop national standards did not allow sufficient time or resources to focus on all of the special facets of child abuse and neglect and meet the deadline for publication initially agreed upon; and that the first set of standards, expected to be published in fall 1977, would not contain a section dealing specifically with the Armed Forces.

The federal project officer discussed with project staff the idea of CARE's input to the development of standards, based upon the substantial work being carried out in this area with several military child advocacy programs in San Antonio and CARE's involvement in a social policy study of military child advocacy.

Contacts were made with representatives of NIAS to learn more about the status of their work and their preferred approach to the design of standards (i.e. content areas, format, and schedule). Follow-up contacts were made with the federal project officer to determine CARE's role with the Armed Forces in the development of standards. Preliminary planning and coordination work has taken place with representatives of DPW's legal services and social services branches in regard to this proposed effort.

Should NCCAN desire and sanction CARE's participation in the development of standards, the following activities are proposed:

1. Consult with appropriate military and State DPW personnel on the objectives and desired benefits of the standards

2. Establish a technical resource group, composed of DPW legal and social services personnel, to assist CARE in the development of standards

3. Develop liaison, communication, and coordination procedures between Project CARE, NCCAN, NIAS, Office of the Surgeons' General and DPW

4. Develop criteria for the selection of subject areas to be addressed by the standards

5. Select subject areas to be included

6. Develop draft standards

7. Revise standards

8. Submit to NIAS

Project CARE welcomes the opportunity to participate in this activity.

Section 5

RESEARCH STUDY

During CARE's planning period a literature review revealed that the incidence, demographic characteristics, case management, and case disposition of child abuse and neglect in the military community had not been well defined, explored, or researched. The incidence of abuse and neglect in the civilian community is also an unknown quantity, with a wide range of estimates existant in the literature. One recent review of the numerous and conflicting incidence studies concluded that information on the incidence of child abuse and neglect in the United States did not exist (Cohen and Sussman, 1975). In spite of this conclusion, speculation is widespread that the incidence of abuse and neglect is significantly greater among military families than among civilians. This speculation appears to be based upon the anecdotal experiences of selected clinicians rather than upon any systematic examination of the problem.

Data on child abuse and neglect in the military are derived from cases reported to military child advocacy personnel. These data are often incorrectly interpreted as the incidence, or the actual occurrence, of abuse and neglect in the military population. Incidence and reported rates are distinctly different variables and are not interchangeable.

Review of the literature on child abuse and neglect has revealed relatively few articles dealing systematically with child abuse in the military community. Wichlacz (1975) reviewed fifty-six cases brought before the Child Abuse and Neglect Board at a U.S. Army hospital in Germany during fiscal year 1972. This hospital served the largest American population concentration in Europe. Physical abuse categorized 36 percent of the cases, sexual abuse 7 percent and neglect was evident in 32 percent. In 9 percent of the cases the victim died. Wichlacz concluded that overcrowded living conditions, social isolation, cultural shock, and separation of household heads constituted significant life stresses which increased the risk of abuse.

Miller (1972) in an unpublished paper, reviewed cases referred to the Infant and Child Protection Council at William Beaumont Hospital, Fort Bliss, Texas. Over the five-year period reviewed by Miller roughly one-third of the cases were classified as physical or sexual abuse and another one-third were categorized as neglect. In 2 percent of the cases the victim died.

The Air Force Office of Special Investigations (OSI) statistics shown in Table 7.1 reflect established cases reported during 1976 to the OSI central registry in Washington in accordance with Air Force regulation 160-38. The rate of neglect reported to the OSI was significantly lower than those shown in the other two studies. Invalid cases were not forwarded to the OSI and, therefore, complete data was not available.

Table 5.1. Previous Military Child Abuse Studies

	N	Physical Abuse	Sexual Abuse	Neglect	Death	Invalidated
Wichlacz 1971	56	36%	7%	32%	9%	16%
Miller 1967-1972	229	27% (+11% abuse & neglect)	7%	36%	2%	13%
USAF OSI 1976	556	62%	17%	19%	2%	No Data

The target population for programs in prevention, detection, and treatment of child abuse and neglect, as well as the universe of the project's research endeavors, was estimated at approximately 200,000 active duty and retired military personnel and their dependents. This group represents nearly 20 percent of the total population of the San Antonio metropolitan area.

Table 5.2. San Antonio Military Population

	Active Duty	Retired
Sponsors	42,344[1]	20,000[1]
Dependents	84,000[2]	30,000[2]

[1]San Antonio Chamber of Commerce, 1976.
[2]Dependency ratio of 3.5 x 24,000 married sponsors.

PURPOSE

Project CARE recognized that, although some variables were reported consistently, a sufficient data base on child abuse and neglect in the military environment did not exist; and that additional research was needed. In August 1976, CARE began a research effort designed to provide much needed information on a wide range of topics including:

- The reported rate of child abuse/neglect among the San Antonio military population
- Referral sources and pathways into local child protection programs
- Demographic characteristics of military families reported to local civilian and military child advocacy programs

- o Stress factors existant in the family situation
- o Military and civilian service delivery systems' response to reported cases of abuse and neglect (time track)
- o Interaction between representatives of complex bureaucracies--military and civilian--in responding to reported cases of abuse and neglect
- o Case management issues related to military-civilian cooperation in child protection
- o Factors associated with differential case disposition of military families
- o Services provided and resources utilized
- o Obstacles to service delivery and interagency coordination
- o Frequency and nature of command involvement; impact of a report of child abuse/neglect on the career of the military sponsor

METHODOLOGY

Between 1 October 1976 and 30 April 1977, each new case of suspected child abuse and neglect in military families reported to the five San Antonio military installations or to the legally mandated community agency for such referrals--The Texas State Department of Public Welfare--was included in the research sample. A structured data schedule was designed and utilized to facilitate uniform collection of information. A certified psychiatric social worker gathered information each case from various sources; including interviews with primary service providers, case record reviews, and attendance of weekly military child protection committee meetings. Cases were followed through closure to gather complete data on case disposition, services needed and provided, and military and civilian resources utilized.

This method of following cases prospectively--from the point of entry into the military or civilian service delivery system through case closure or stabilization in treatment--was selected over a retrospective review of case records for several reasons. Such a retrospective case record review was conducted in late 1975 by Project CARE; and was hampered by limitations, inconsistencies, and omissions in the records. Social service records sometimes omitted information related to the victim's medical condition or medical treatment received. The idiosyncratic recording styles of clinicians also made consistent data collection difficult. In addition, because child abuse cases often involved intervention by multiple agencies and professional disciplines, no single case record contained all pertinent data from initial case identification and opening through treatment and closure. This incomplete case recording prevented a comprehensive assessment of medical, social, psychological, and environmental stress factors that might have contributed to an abusive or neglectful family situation.

Since no central case record repository or referral index existed, accurate determination of the total number of military families reported to civilian and military child protection personnel was impossible.

The methodology of the 1976-1977 research study was selected over the 1975 case record review because multiple data sources could be tapped, maximizing research variables and enhancing accuracy of data. Inconsistencies in case data could be easily resolved, through direct contracts with primary service deliverers, while the cases were open and active rather than relying solely on case record documentation; which is a limited data source. Attendance at multidisciplinary team case reviews would facilitate data collection on the roles and involvement of multiple service deliverers.

Cases which were air-evacuated from other installations to Brooke Army Medical Center (BAMC) or Wilford Hall Medical Center (WHMC) for medical treatment were excluded from the study, due to the limited data available and the case management and other special problems which characterized these cases. This is one possible area for future research. Cases opened prior to 1 October 1976 and active beyond this date were also excluded from the study.

Because there are variations in definitions of abuse and neglect by military and civilian service deliverers, the following definitions were used:

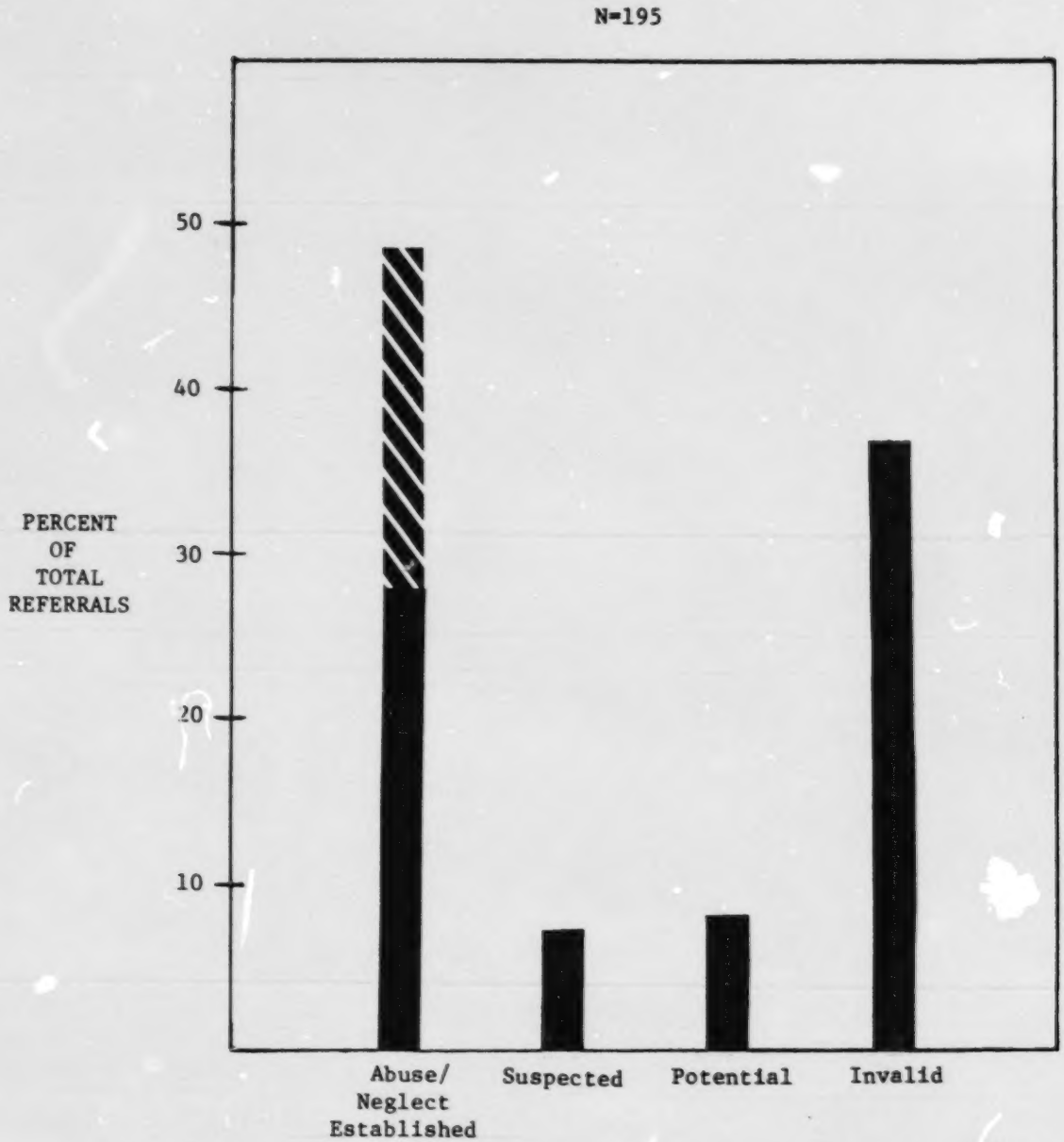
- Child abuse -- minimal or gross physical, mental, or emotional injury/trauma, sexual abuse, sexual molestation or maltreatment of a child resulting from non-accidental causes, ordinarily inflicted by the direct or indirect actions of persons responsible for the child's care or welfare.

- Child neglect -- acts of omission or commission which deprive a child or living conditions which provide the minimally needed physical and emotional requirements for life, growth, and development. These acts may cause the child to suffer from: lack of food, inadequate housing and clothing, lack of needed medical attention, abandonment, lack of supervision or guidance, unmet educational needs, or other deprivations.

PRELIMINARY RESULTS

During the seven-month study period, 195 military families were reported to civilian and military child protection personnel. As Figure 5.1 illustrates, one-half of these referrals were established as cases of abuse or neglect, one-third were invalidated, and the remainder were considered suspected or potential abuse/neglect cases.

Figure 5.1 Case Status After Intake



Active duty military families were involved in 83 percent of the established cases, while retired families were involved in 17 percent. In 6 percent of the cases the mother was the military sponsor. Military sponsors were heavily concentrated in the E1-E7 enlisted pay grades. Of the established cases, 5 percent involved officer personnel. Twenty percent of the families lived on a local military installation.

Section 6

CONFERENCES AND SEMINARS

As part of its commitment to provide education for both the military and civilian communities, Project CARE has planned and been involved in several conferences and seminars. CARE's participation in conferences and seminars has consisted of money grants, consultations, actual planning and implementation, and participation as speakers.

Some of the conferences and seminars Project CARE has been involved in during the past year, as well as projections for further involvement, are described below.

"Behind Closed Doors" was the title given the third annual conference held at Trinity University, San Antonio, on June 17-19, 1976. The conference, a conjoint effort between the military and civilian communities, explored topics not discussed during either of the previous conferences (1974 had been on "Cycle of Abuse: Treatment for the Family," and 1975 on "Child Abuse Prevention: The Community's Responsibility").

The conference was sponsored primarily by Project CARE. Sixteen other organizations, agencies, businesses, and a private foundation also provided financial backing and in-kind contributions. Most of the sponsors were represented on the conference planning committee. This provided consistent and direct input from many community service agencies, as well as insuring that the subjects included in the conference program met the training needs of personnel attending the three-day educational program.

The subjects of sexual abuse, child neglect, group therapy, drug use in troubled families, abuse and neglect, and the unique problems of military families were reviewed from the medical, legal, human services, and lay perspectives. Presentation methods included film, theater, discussion groups, lectures, and a mock child abuse trial.

In addition to these modes of delivery, the following materials were provided to participants:

- A conference packet containing additional information about the facilitators of various sessions; i.e., panel, drama, trial, and workshop
- A list of resources summarizing the child abuse and neglect services in San Antonio, prepared by Project CARE
- A bibliography on child abuse and neglect, including a listing of media and educational films available nationwide
- A glossary of legal terms regarding child abuse and neglect prepared by URSA, San Francisco
- A New Bill of Rights for Children prepared by Shirley Camper Soman

- An exhibit of materials sponsored by agencies providing services in the field of child abuse, neglect, family therapy, treatment, and drug abuse

- A book fair was available to those in attendance all day Friday, June 18. Participants could survey pertinent literature without pressure to make purchases.

- Continuing education credit was made available from the American Academy of Family Practitioners, the American Nursing Association, the San Antonio College for Physicians, and other professional associations with members in attendance.

In addition to participation in the San Antonio Child Abuse Conference, CARE staff members have also participated in workshops, panels, etc. at other conferences. Some of these have been: Annual Conference of Child Abuse and Neglect Project Directors, sponsored by the National Center for Child Abuse and Neglect in Annapolis, Maryland in November 1976; Military Installation Workshop in Annapolis, Maryland, also in November 1976; The Second Annual CHAP (Children have a Potential) and Child Advocacy Course at the School of Health Care Sciences at Sheppard AFB, Texas in October 1976; a child advocacy workshop held at Fort Polk, Louisiana in March 1977; the Second Annual National Conference on Child Abuse and Neglect in Houston, Texas in April 1977; and the American Public Welfare Southwest Regional Training Conference in Oklahoma City, Oklahoma in March 1977.

Through participation in conferences and seminars outside of CARE's immediate environment, the project has disseminated information on military child advocacy to a national audience and provided a foundation for potential military-civilian replication of CARE's experiences. During its final year, CARE will maintain its efforts to disseminate the information acquired at other conferences and seminars; particularly those with military affiliations.

The educational objectives of the projects include the planning and presentation of seminars to groups that could have a great impact on the prevention and early identification of child abuse and neglect cases. Two seminars were held within the second year; a training seminar for child care center staff and a seminar for law enforcement personnel. In both seminars, participants from both the Army and Air Force were included. Civilian participants were also invited to attend the law enforcement seminar. The following descriptions of the programs of the two seminars detail the extensive planning and involvement required.

SEMINAR FOR CHILD CARE CENTER STAFF

Child advocacy involves intervention on behalf of children at the institutional as well as the individual level. Remediation of individual problems cannot occur if institutional systems fail to meet the needs and right of children and families. In accordance with this interpretation

Established abuse and neglect cases were distributed among the branches of service as follows:

Table 6.3

Branch	Percentage
Air Force	60
Army	35
Navy	1
Marines	2
Reservists	2

As of 31 July 1977, 66 percent of the cases in the sample were closed. The remaining cases were receiving ongoing DPW protective services or treatment from military or community service providers. Seven percent were completing the intake and assessment process prior to determination of the need for services.

Open cases are being followed while they receive ongoing protective services and therapy. Closed cases are being coded and keypunched prior to computer analysis. Completion of data collection for the 195 cases is anticipated by September 1977 and will be followed by a detailed analysis of the entire sample to be produced and disseminated by CARE in October or November 1977. Additionally, the results will be submitted for journal publication. CARE has also been invited to present preliminary findings to the Military Family Research Conference, sponsored by the Naval Health Studies Branch, in San Diego, California in September. Considerable interest in the study has been generated and requests for data have been received from numerous sources including universities and federal agencies. The provision of an accurate data base is expected to increase data understanding of abusive and neglectful behavior and facilitate planning and assessment of military/civilian child protective services programs.

of advocacy, CARE planned and implemented a program of strengthening the quality of day care services available to military families.

Many children attend day care centers for eight to ten hours daily, five days a week. Thus, child care workers must provide the stimulation that will enable a child to grow and develop. In addition, if a child from an abusive, neglectful family comes to the day care center, the child care worker needs the training to recognize a troubled child and act appropriately to involve resources that can strengthen the family's nurturing abilities.

In order to facilitate the provision of quality care at the five military day care centers, Project CARE gave high priority to the augmentation of staff training. The goal of such training was to provide practical information of immediate value to workers providing daily child care. This ultimately benefited the children in their care and stimulated and encouraged child care staff to seek additional training on an ongoing basis.

Visits to the centers were made to assess the need for staff training. When it was learned that no formal training was offered, CARE began planning a series of lectures, seminars, and demonstrations in coordination with Army community health nurses.

The program consisted of five presentations, each an hour in length, and concluded with a question and answer period. The topics were: child growth and development, nutrition, fire prevention and safety, first aid, and creative play activities. Topics were selected because they were considered essential elements of a quality training program. In addition, these subject areas would provide a sound foundation for future training endeavors.

To encourage maximum participation, the seminars were planned for the noon hour when children were napping. Minimal staff supervision was required at this time. Offering seminars in the evening of after hours was considered unfeasible because fewer workers could attend.

The proposed program was outlined to the child care center directors, who were highly receptive. The proposal was then presented by CARE to the appropriate day care center boards of directors. Following their approval, formal authorization was requested and received from the installation commanders. Then detailed planning and coordination began.

The series of seminars was presented at each of the five military installations in San Antonio. Representatives of various organizations presented their areas of expertise. Both Air Force and Army representatives were involved because of possible differences in regulations and procedures.

The classes began in August and continued through December. The following chart outlines the seminar topics and guest speakers:

SPEAKERS

TOPIC	ARMY	AIR FORCE
Child Growth & Development	Community Health Nurses	Aerospace Nurses
Nutrition	Dietician	Dietician
Fire Prevention and Safety	Fire Marshal & Safety Officer	Fire Marshal & Safety Officer
First Aid	Red Cross	Red Cross
Creative Play	Project CARE	Project CARE

Major areas covered in each seminar topic were:

Child Growth and Development

- o Physical growth and development--changes in size and function of the body, height and weight progressions
- o Intellectual growth and development--communication skills
- o Emotional growth and development--ability to handle anxieties

Nutrition

- o Value of proper nutrition through childhood and adulthood
- o Four major food groups and suggestions for planning meals to include them
- o Shopping tips for nutritional soundness
- o Weight control in children and adults
- o Suggested menus for children of various ages

Fire Prevention and Safety

- o Types of fires and appropriate method of extinguishing each
- o Fire prevention pointers--proper disposal of oily rags, precautions regarding storing materials near water heaters
- o Actual demonstration of a fire and extinguishing procedure
- o Actual practice for the workers in using an extinguisher

- o Value of early warning devices such as smoke detectors
- o Safety hazards for children
- o Proper procedures for sanitary food preparation
- o Necessity of proper supervision of children inside and outside
- o Importance of possessing a valid health card

First Aid

- o Discussion, demonstration, and practice in providing artificial respiration
- o What to do to stop bleeding, alleviate choking, and similar emergency situations
- o Discussion of the full Red Cross first aid course and the importance of reacquainting oneself with techniques even if previously exposed to first aid training

Creative Play

- o Age appropriate activities for children
- o Demonstration of toys which can be easily and inexpensively made and how they stimulate and support a child's development

The seminars generated considerable interest and were well attended at each of the five military installations. Participants were requested to complete a written questionnaire assessing each seminar topic. The results of the evaluation indicated that the original goals of the program were achieved. Practical information on a variety of topics of immediate value to child care workers had been provided. In addition, child care staff were stimulated to seek additional training through the Child Development Associate (CDA) course at Incarnate Word College. The CDA Consortium is a non-profit, private corporation established to assess the competency of individuals who work with center-based groups of children three-to-five years of age. The CDA certificate is awarded to individuals who successfully demonstrate competence and is soon to be required of all child care providers. Representatives of each military child care center enrolled in the CDA course. At one center fifteen staff members enrolled.

An unexpected benefit of the seminars has been the strengthening of communication through the initiation of regular meetings of the directors of the five centers. Project CARE encouraged and sponsored the first such meeting held 5 January 1977. The meeting fostered communication between directors about common concerns and provided a forum for exchange of ideas about the recently completed seminar series, the future role of Project CARE, and the value and importance of the CDA certificate and training program.

Project CARE was asked to provide consultation, information, and referral services to the child care centers.

The directors considered the seminars valuable and offered the following suggestions for future seminars:

- Offer each seminar once and invite workers from all five military child care centers to attend, rather than having separate presentations at each center
- Include a session on child abuse and neglect
- Child growth and development segment should include psychosocial as well as physical development
- Devote additional time to creative play activities with one session focusing on activities for children under three years old and a second session for children three-to-six years of age
- Offer additional training in first aid

Some of the topics were considered repetitious of other training. For example, a recommendation was made to discontinue the fire prevention presentation because the fire department conducts periodic inspections and fire drills.

SEMINAR FOR LAW ENFORCEMENT PERSONNEL

A one-day seminar was planned as the first step in examining the role of the police officer in relation to child abuse and neglect. Specifically, the seminar was designed for military and civilian law enforcement personnel involved in middle management or training duties. This group was chosen as the one most able to affect change by influencing higher administrative staff, as well as directing those under their command. Also included as participants were military and civilian judicial and legal professionals and representatives from social service agencies. These individuals were invited because of the importance of effective interface between them and law enforcement agencies regarding child abuse and neglect cases.

To plan the seminar program a series of meetings with administrative staff--both military and civilian--from law enforcement, legal, and social service agencies were held in April and May 1977. A group of key people was invited to serve as a planning committee and to meet with Project CARE to provide suggestions on an educational module for law enforcement personnel. Research of the literature was conducted and a bibliography compiled. Training materials were acquired and shared with law enforcement training staff. Consultants in the field of law enforcement education were asked to participate and assist in developing a program of education for law enforcement personnel.

The planning committee and Project CARE established the following goals for the seminar:

- To provide basic information to military and civilian police on the scope of the problem, on reporting requirements; and on the designated responsibilities of military and community agencies for identification, assessment, and treatment
- To clarify areas of legal ambiguity when dealing with troubled military families living either on or off post
- To explore the training needs of law enforcement personnel
- To strengthen mutual understanding of the complementary role of law enforcement and child welfare agencies, resulting in increased and earlier case identification and prevention of child maltreatment
- To develop a task force to implement the recommendations of the seminar participants

Because child abuse and neglect is clouded by many attitudinal and emotional issues, a seminar program addressing these issues, as well as sharing information, was essential. Speakers were chosen to address the following topics: Texas child abuse and neglect laws; federal law; the Army and Air Force child advocacy regulations; the functions of the agency mandated to respond to child abuse and neglect cases; the role of the court; child abuse, its recognizable signs and its causative factors; the basis for police involvement in child abuse and neglect; and the training needed to make the role of the police officer more effective in child maltreatment situations. The speakers attempted not only to provide information but also to stress intervention as a means of improving the quality of life of families experiencing difficulties as well as emphasizing a non-punitive model of intervention.

The seminar was held on 24 June 1977 and 88 military and civilian personnel attended. The participants represented the following agencies:

- Fort Sam Houston Provost Marshal Office
- Randolph AFB Security Police
- Brooke AFB Security Police
- Lackland AFB Security Police
- City of San Antonio Police Department
- Armed Forced Police Detachment, San Antonio
- Navy Master-at-Arms Training Detachment, Lackland AFB
- Provost Marshal Office, Health Services Command, Fort Sam Houston

- Criminal Investigations Division, 3rd Region, Fort Sam Houston
- Security Police Academy, Lackland AFB
- Office of Special Investigations (OSI) Detachment, Lackland AFB
- OSI Detachment, Brooks AFB
- OSI Detachment, Kelly AFB
- Social Actions, Drug and Alcohol Control, Kelly AFB
- Social Actions, Brooks AFB
- Alamo Area Council of Governments, Criminal Justice Division, San Antonio
- City of Converse Police Department
- Universal City Police Department
- Bexar County Juvenile Probation Department
- Bexar County Child Welfare, Department of Public Welfare
- Children's Service Bureau, San Antonio
- District Attorney's Office, San Antonio
- Equal Opportunity and Treatment Office, Lackland AFB
- Staff Judge Advocate Office, Fort Sam Houston
- Base Judge Advocate Office, Lackland AFB
- Health Services Command, Judge Advocate Office, Fort Sam Houston
- Staff Judge Advocate Office, Randolph AFB
- Child and Adolescent Guidance Clinic, Lackland AFB
- Child Advocacy Program, Fort Sam Houston, Lackland AFB, Brooks AFB, and Randolph AFB
- Army Community Health Nurses, Fort Sam Houston
- Army Community Service, Fort Sam Houston
- Bexar County Mental Health and Mental Retardation Program
- Social Work Service, BAMC, Fort Sam Houston
- 131st District Court, Bexar County

- State Department of Public Welfare, Legal Division, Austin, TX
- National Council of Christians and Jews, San Antonio
- San Antonio Child Abuse Council
- Advocacy Program for Victims of Crime, San Antonio
- Texas Crime Prevention Institute, Southwest Texas State University, San Marcos, TX
- California Specialized Training Institute, San Luis Obispo, CA
- International Association of Chiefs of Police, Gaithersburg, MD
- U.S. General Accounting Office, Washington, D.C.

The seminar program was designed to allow the fullest dissemination of information and the greatest generation of ideas. In the first morning session, a panel of six speakers addressed information to serve as core material for discussion throughout the day, as well as defining possible new approaches to improving services to military families.

After the panel, the participants were divided into three groups. One group consisted of key administrative staff who met with Project CARE's director to discuss varied problems which arise in the course of working with families, and possible solutions. The other groups were moderated by two consultants, who brought to the seminar expertise in working with civilian and military police in the area of child abuse and neglect. One consultant, Dr. Andrew Crosby, is the director of the child abuse project of the International Association of Chiefs of Police (IACP). Dr. Crosby worked with police departments across the country to determine their training needs, and demonstrating the National Council of Child Abuse training materials. Dr. Crosby also deals, within the IACP, with personnel issues in law enforcement including selection, promotion, and organization. Dr. Crosby has a Ph.D. in Organizational Psychology from the University of Tennessee and worked in state government before joining the IACP.

Lieutenant Colonel Fred Villella, USA (Ret.), the other invited consultant, is currently an instructor at the California Specialized Training Institute. Colonel Villella served, prior to his retirement from the Army, as Provost Marshal at Fort Carson, Colorado. He is a member of Governor Brown's Crime Resistance Task Force and is also a member of the National Youth and Juvenile Justice Committee. The topic discussed by these two groups was "Child Abuse and Neglect--The role of the Police and the Legal Basis for Police Involvement."

In the first part of the afternoon, all participants were divided into two groups and discussed the topic "Training Needs of Law Enforcement Personnel on Identification of Child Abuse and Neglect, Available Community Resources, and Reporting Procedures." The group discussions were again facilitated by Dr. Crosby and Colonel Villella, and an effort was made to assign participants to ensure their exposure to both consultants.

The final afternoon session brought all the participants together to recapitulate the topics discussed during the day. Participants were asked to complete a seminar evaluation. The purpose of the evaluation was to obtain feedback to determine if the objectives of the seminar had been achieved. A second purpose was to explore with participants their interest in attending a follow-up seminar. The evaluation reports were also useful in identifying persons in a position to effect change within their agencies.

The seminar was a beginning. From this beginning those in law enforcement must make plans. Plans for training law enforcement personnel to deal effectively with family crisis, for changing the attitudes of personnel regarding child abuse and neglect, for exploring new responses to cases of child maltreatment, and for establishing open communication between law enforcement and human service agencies.

To assist law enforcement agencies in their task of role definition; proceedings of the seminar, as well as recommendations and additional key information, have been compiled and disseminated to the participants.

PROJECTIONS

Project CARE plans to continue allocating financial support and manpower to conduct additional conferences during its third year. Preparations for a conference to be held in January 1978 are currently underway. As recommended by the 1976 conference report, the theme of the conference will be centered on adolescents and the problems that beset them, such as: substance abuse, early marriage and parenthood, abuse by or conflict with parents and other authority figures, and legal difficulties. The keynote speakers for the conference have been secured and the workshops tentatively set. Attempts will be made to use local professionals to present the workshops, as the purpose is not only to raise issues but to provide local and accessible solutions.

In addition to participation by Project CARE and the San Antonio Child Abuse Council, efforts are being made to include all other relevant military and civilian human service agneices, not on the Council, that deal with adolescents. The conference planning committee is presently seeking input from as many agencies as possible so the conference may truly address the needs of the community.

It is hoped that this conference will result in a tangible network of services for adolescents.

During the third year Project CARE will repeat the seminar for child care center staff. The recommendations of the center staff will determine the topics to be presented. A more extensive child abuse and neglect program is planned, to includ techniques by which the staff can approach parents on minimal neglect situations, (i.e. child not bathed and wearing same clothes for seferal days). Topics not covered in the first seminar will be given priority in the program. The instructor of the CDA course at Incarnate Word College will serve as a consultant on second seminar planning.

Additional seminars are planned. One group identified as crucial, in the early identification and treatment of child abuse and neglect, is the military chaplains. So far the project has not addressed this group in a major way and it is important that this be done. Preliminary meetings with appropriate administrative staff at all five installations will be initiated in September 1977.

Another seminar to be conducted during CARE's third year will assemble physicians from the military and civilian hospitals in San Antonio to establish uniform reporting and referring procedures for presenting child abuse cases.

Section 7

ACCOMPLISHMENTS

This section lists some of the major accomplishments of Project CARE from July 1976 through August 1977. Ongoing revisions and refinements of the procedures and techniques developed are continuing.

- Developed and presented a variety of informational seminars and training courses to military and civilian professionals involved in the prevention, diagnosis, and treatment of child abuse and neglect. Conducted an ongoing public awareness campaign through the distribution of posters and other printed materials on the military installations
- Planned and budgeted media presentations for military audiences on child abuse and neglect in the military community
- Provided financial, planning, and implementation support for San Antonio Child Abuse Conference
- Developed and initiated seminars in normal child development for day care center workers
- Provided course in Parent Effectiveness Training at Fort Sam Houston
- Developed and presented parenting education program on OB-GYN ward at WHMC
- Provided financial support for the San Antonio Crisis Center
- Negotiated and contracted crisis child care services (purchase of day care hours, purchase of space at San Antonio Children's Center, participation in foster home recruitment)
- Sponsored and conducted a symposium for law enforcement and human services professionals
- Conceptualized and disseminated a procedures manual on the interface between civilian and military child advocacy service deliverers
- Establishment of a pediatric social work liaison role at WHMC
- Staffed a child abuse telephone crisis line for military families assigned to Fort Sam Houston
- Pilot-tested systematic social work intake and evaluation processes including home visits with military families

- Integrated and expanded role of pediatric nurse practitioner at WHMC to include the provision of home visits on child abuse/neglect cases for physical evaluation, medical management follow-up, immunizations, and development counseling

- Consulted with child advocacy officers on development of procedures for initial case presentation and follow-up to councils, and assisted in clarification of multidisciplinary team role

- Explored feasibility of special Parents Anonymous group for military families

- Participated in and facilitated meetings among DPW, the five military child advocacy officers, and legal representatives to identify, clarify, discuss, and resolve legal issues

- Produced child advocacy resource handbook for professionals in community and military

- Implemented and completed parenting education class for adolescents

- Implemented program for parents in Well Baby Clinic at BAMC

- Implemented and completed seminars on normal child development for child care workers

- Conducted a case management research study

- Initiated a social policy study on the military community's response to child advocacy

- Conceptualized potential pilot placement of regional protective services staff on military installations

- Identified possible alternatives to ensure continuation of the project's mission, services, and activities

Section 8

TASKS AND SCHEDULE

This section presents the schedule of major tasks for the remainder of the project. Because of the large number of ongoing project activities there is a certain amount of overlap from one project year to the next. Stages of negotiations, implementation, and revision are dealt with elsewhere in the report. Methods of dissemination of project information are reviewed in Section 9.

Gantt charts and tracking forms are used by Project CARE to monitor project progress. Both reflect scheduled and actual dates for initiation and completion of project activities. Gantt charts also provide a method for determining the number of project tasks which occur simultaneously, and therefore provide data for assessment of staff time allocations.

The tracking forms define primary staff responsibility for each task and provide a regularly updated review of the status of each activity. Also included are brief remarks concerning factors--internal or external to Project CARE--which affect the status of an activity. Remarks are expanded upon in weekly status reports which are submitted to the project director.

Because the tracking forms are disseminated to various State Department of Public Welfare planners and administrators, they serve the additional function of providing information about CARE's progress and inviting comments regarding CARE's activities.

PROJECT CARE STATUS REPORT AS OF: August 31, 1977

OBJECTIVE	RESPONSIBLE INDIVIDUAL/ OFFICE	(SCHEDULED START) ACTUAL START	(SCHEDULED COMPLETION) ACTUAL COMPLETION	CURRENT STATUS	REMARKS
I. Acquaint military families with available resources					Completion date is date initial distribution is complete. Distribution is ongoing project activity.
A. Produce and disseminate pamphlets, posters, etc. for military audience	Grady, Media Services	3-76	2-15-77	Complete	DPW-produced child abuse booklets have been distributed through Fort Sam Houston welcoming packets.
B. Submit press releases	Grady	7-15-75	(6-30-78)	On Schedule	
II. Produce and disseminate resource handbook to professionals in community and military	Grady	3-1-76	2-15-77	Complete	Project continues to receive and respond to requests for handbook. Selected entries in handbook will be updated during final project year.
III. Plan, implement, and evaluate modules to educate professionals and community in identifying and helping troubled military families					Completion date is date module is fully implemented. Implementation and evaluation are ongoing project activities.
A. Orientation for medical professionals assigned to Brooke Army Medical Center (BAMC) and Wilford Hall Medical Center (WHMC)	Garcia	(7-15-76) 5-15-76	(3-31-77) (12-31-77)	On Schedule	

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OBJECTIVE	RESPONSIBLE INDIVIDUAL/ OFFICE	(SCHEDULED START) / ACTUAL START	(SCHEDULED COMPLETION) ACTUAL COMPLETION	CURRENT STATUS	REMARKS
B. Module for students of Academy of Health Sciences, BAMC Clinical Specialist School, and BAFB School of Aerospace Medicine	Garcia	1-15-76	Unscheduled		Future presentations being assessed.
C. Module for junior/ senior high schools on military installations (five bases)	Garcia	5-30-76	(4-30-78) 1-31-77	Complete	
D. Seminar for legal and law enforcment personnel	Garcia	1-14-77	(7-15-77) 6-30-77	Complete	Seminar held 6-24-77. Professional roles and training needs were identified and discussed. Seminar proceedings are complete. Negotiations for future training are continuing.
E. Organize speakers bureau	Garcia	11-15-76	(4-30-77) 4-30-77	Complete	Participants have been recruited. CARE receiving speaking requests and assigning speakers.
F. Slide show on child abuse for military audiences	Grady	5-15-76	(11-15-76) (12-31-77)	On Schedule	Script concept has been developed. Continuing to negotiate the contracting and logistics of the production.

OBJECTIVE	RESPONSIBLE INDIVIDUAL/ OFFICE	(SCHEDULED START) ACTUAL START	(SCHEDULED COMPLETION) ACTUAL COMPLETION	CURRENT STATUS	REMARKS
G. Seminar for chaplains	Garcia	7-15-77	(12-31-77)	On Schedule	Conceptualization has begun.
IV. Expand existing secondary services					
A. Expand crisis center hot-line referral services	Garcia	5-1-76	(9-30-77)	On Schedule	
B. Utilize contracted day care hours and short-term residential psychiatric care	Garcia	7-1-76	(6-30-78)	On Schedule	Efforts being made to increase utilization of day care contracts.
C. Facilitate recruitment of military families to provide foster care for DPW	Garcia	9-1-76	(4-30-77) 4-30-77	Complete	Activity coordinated with military, DPW, and Foster Care Interagency Board. Feature story published 4-15-77. Additional story planned at RAFB.
D. Support Parents Anonymous Group	Grady	9-1-76	(6-30-77) (8-31-77) 8-31-77	Complete	Media and organizational support provided to existing chapter by CARE.
V. Plan, negotiate, implement, and evaluate a viable network of military and community agencies serving military families	Marley, Staff	(7-1-76) 6-30-76	(6-30-78)	On Schedule	Regular conferences continuing between DPW Region 09, military, and CARE regarding network and role responsibilities. An Operating Procedures Manual

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OBJECTIVE	RESPONSIBLE INDIVIDUAL/ OFFICE	(SCHEDULED START) ACTUAL START	(SCHEDULED COMPLETION) ACTUAL COMPLETION	CURRENT STATUS	REMARKS
					among BCCW, WHMC and CARE was printed and disseminated on 5-12-77.
VI. Design and implement multidisciplinary staffing model (for treatment and case management) at BAMC and WHMC					Completion date is date module is fully implemented. Implementation and evaluation are ongoing project activities.
A. Design case management procedures and forms	Killebrew	9-15-75	9-76	Complete	
B. Design service delivery model	Killebrew				
1. WHMC		12-1-75	8-76	Complete	
2. BAMC		(10-1-76) 10-1-76	(10-15-76) (11-15-76) 11-15-76	Complete	
C. Plan and negotiate model implementation	Killebrew				
1. WHMC		2-1-76	8-31-76	Complete	
2. BAMC		(10-16-76) 10-16-76	(10-31-76) (11-30-76) 11-30-76	Complete	

III

OBJECTIVE	RESPONSIBLE INDIVIDUAL/ OFFICE	(SCHEDULED START) ACTUAL START	(SCHEDULED COMPLETION) ACTUAL COMPLETION	CURRENT STATUS	REMARKS
D. Implement model and provide direct services to military families	Killebrew All Model Participants				
1. WHMC		3-1-76	(3-31-78)	On Schedule	Ongoing project activity.
2. BAMC		3-1-76	(3-31-78)	On Schedule	Ongoing project activity.
E. Evaluate and refine model	Killebrew All Model Participants				Evaluating and refining are ongoing project activities.
1. WHMC		(7-76)	(8-76) (12-31-77)	On Schedule	CARE and CAO have developed a manual of roles and functions of military and community service deliverers in the Child Advocacy Program.
2. BAMC		(11-16-76) 11-16-76	(11-30-76) (12-31-77)	On Schedule	Multi-departmental task force created by Gen. Baker to facilitate accomplishment of model program prior to CARE's termination
F. Ongoing inservice training for project service delivery staff	Killebrew	3-76	(4-30-78)	On Schedule	

OBJECTIVE	RESPONSIBLE INDIVIDUAL/ OFFICE	(SCHEDULED START) ACTUAL START	(SCHEDULED COMPLETION) ACTUAL COMPLETION	CURRENT STATUS	REMARKS
G. Assess feasibility of & facilitate DPW Protective Services participation in multi-disciplinary staffing model at each medical center	Marley, Killebrew	(12-1-76) 12-76	(6-30-77) 6-30-77	Complete	DPW roles are defined and included in CAO manual.
H. Refine staffing model for remote bases: Randolph AFB	Aultman	11-18-76	(1-18-77) (4-30-78)	On Schedule	Input from CARE requested in rewriting Wing Supplement for Child Advocacy. CARE continues to provide direct services and identify procedural and systemic gaps.
I. Utilize WHMC Pediatric Nurse Practitioner for medical follow-up	Killebrew	4-15-76	(12-31-77)	On Schedule	Active member of child protective council and Child Advocacy Program.
J. Negotiate and implement CARE staff functioning as liaison at WHMC between Pediatrics and Child Guidance Clinic	Dumas	(3-1-77) 3-1-77	(4-30-78)	On Schedule	Roles and responsibilities are being negotiated. Procedures for identification and intervention are being reviewed.
VII. Strengthen and coordinate project activities with existing Child Protective Council at Fort Sam Houston and WHMC, and newly established council at RAFB					

OBJECTIVE	RESPONSIBLE INDIVIDUAL/ OFFICE	(SCHEDULED START) ACTUAL START	(SCHEDULED COMPLETION) ACTUAL COMPLETION	CURRENT STATUS	REMARKS
A. Draft and implement new guidelines for Council case presentations and assessments	Killebrew, Marley				
1. BAMC		3-1-77	(3-31-78)	On Schedule	Due to military staff turnover, existing guidelines are being reassessed.
2. WHMC		8-1-76	(3-31-78)	On Schedule	
B. Explore, define, and coordinate a core case management team (including ward and ER personnel)	Marley, Killebrew				
1. BAMC		6-76	(4-30-78)	On Schedule	
2. WHMC		2-76	(4-30-78)	On Schedule	
C. Examine, plan, negotiate, and implement Child Advocacy Referral System at BAMC	Marley, Killebrew, Mathis	(2-1-77) 3-15-77	(9-30-77)	On Schedule	Pilot period has passed halfway mark. CARE serves as point of entry for new referrals. Central trauma file is being studied. Departmental SOP's are being developed.

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OBJECTIVE	RESPONSIBLE INDIVIDUAL/ OFFICE	(SCHEDULED START) ACTUAL START	(SCHEDULED COMPLETION) ACTUAL COMPLETION	CURRENT STATUS	REMARKS
VIII. Develop, implement, and expand program of parenting education for adolescents & military families					
A. Implement program of parenting education for adolescents at FSH	Garcia	9-8-76	(10-76) 10-28-76	Complete	Seocnd course being negotiated for Fall 1977. Schools on FSH and RAFB are being considered.
B. Reinitiate parenting education on OB Ward at WHMC	Dumas	5-15-77	(4-30-78)	On Schedule	CARE has redefined OB-GYN role to serve as consultant and to accept child advocacy referrals rather than re-initiating parenting presentations.
IX. Implement and evaluate seminar on normal child development for child care workers	Garcia	3-16-76	12-15-76	Complete	Seminar series has been completed. CARE serving as consultant to center directors re: future staff development. Second seminar series is being planned.
X. Develop and pilot test innovative staffing model for DPW casework with military	Marley, Killebrew	4-15-76	(3-31-77) (12-31-77)	On Schedule	Feasibility study begun. Conceptualization of pilot placement roles and responsibilities continuing.

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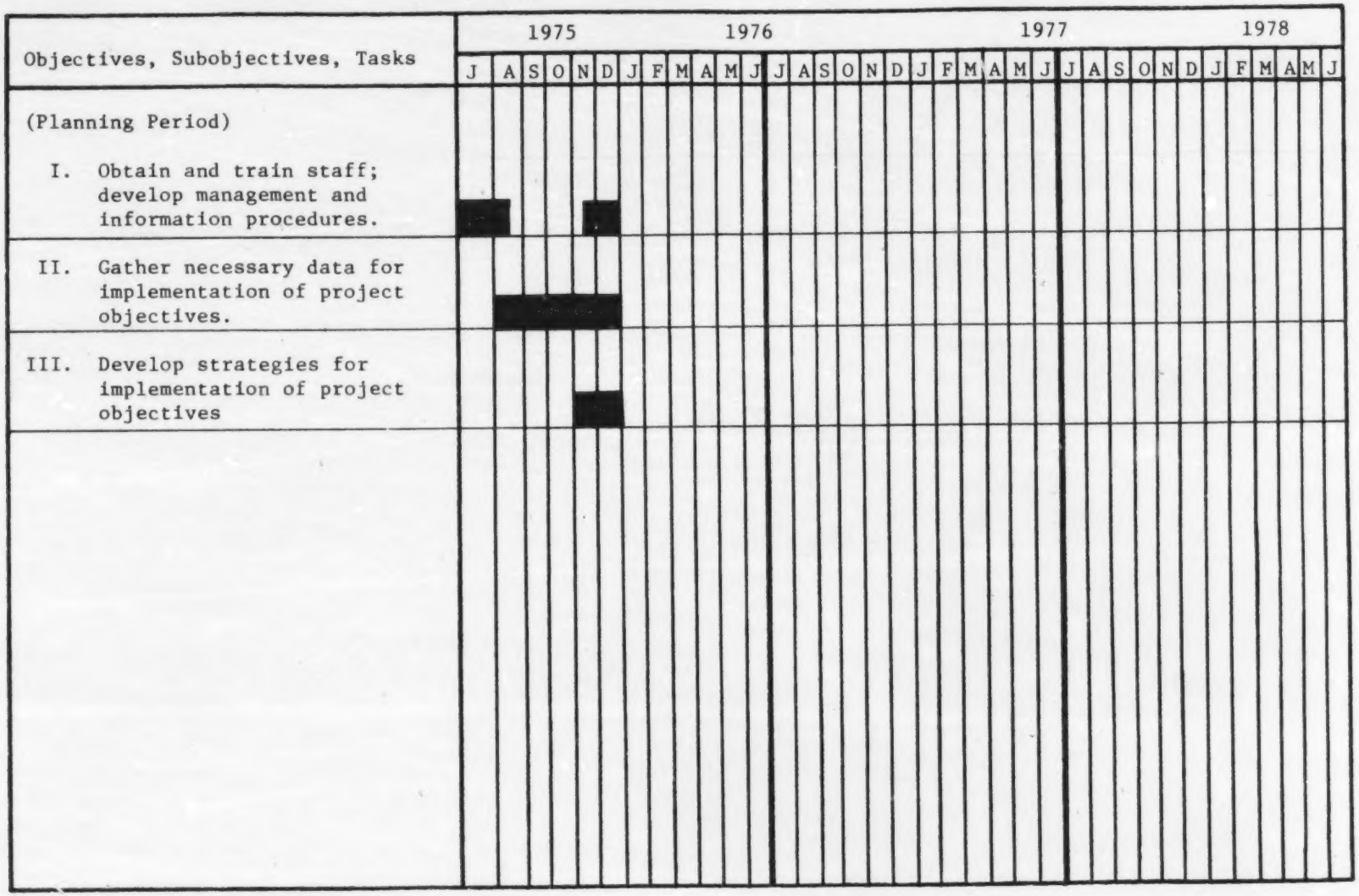
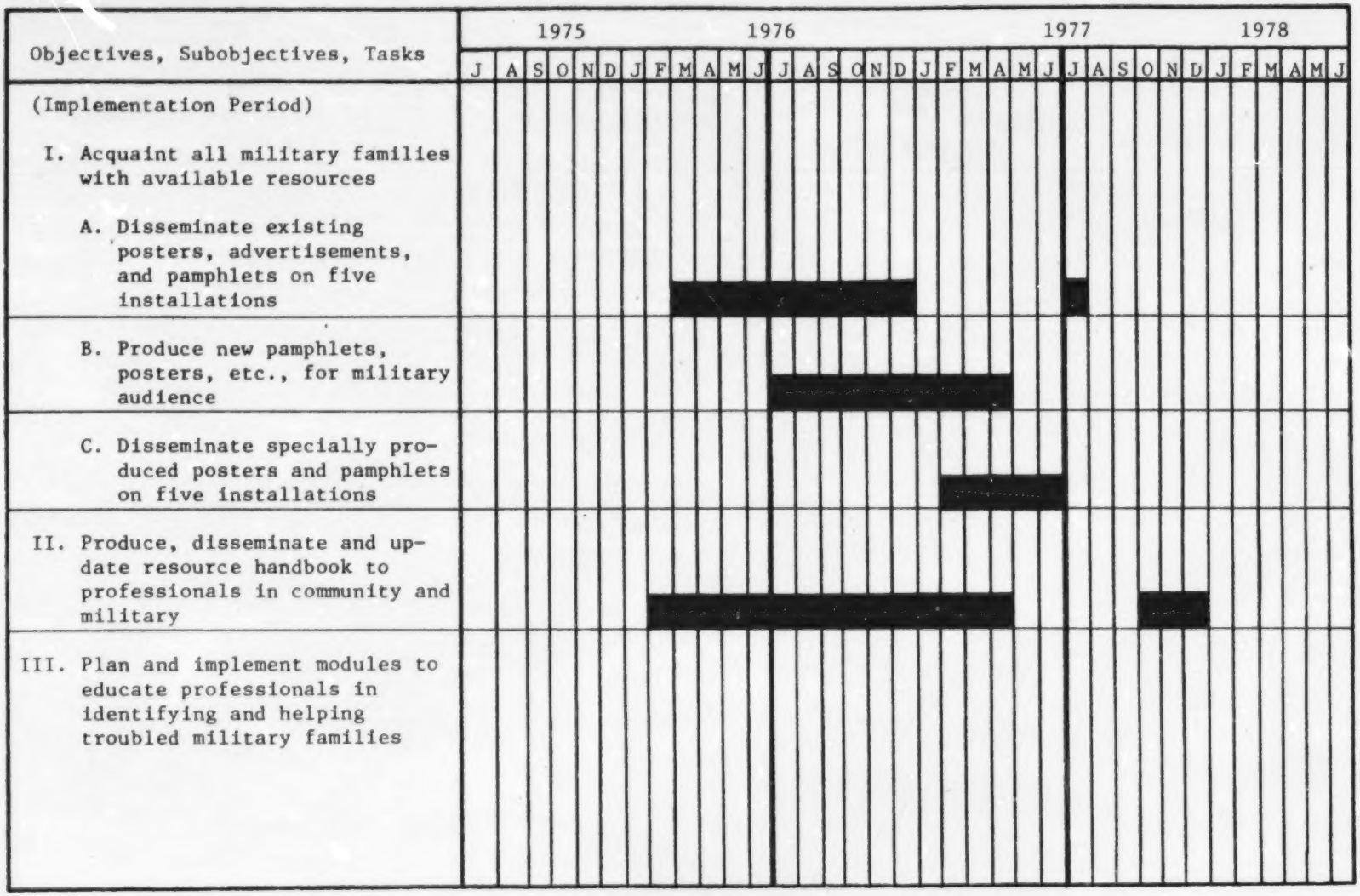
OBJECTIVE	RESPONSIBLE INDIVIDUAL/ OFFICE	(SCHEDULED START) ACTUAL START	(SCHEDULED COMPLETION) ACTUAL COMPLETION	CURRENT STATUS	REMARKS
XI. Monitor project activity and provide data for CPI (independent) Evaluation	Schnall, Project Staff	3-1-76	(6-30-78)	On Schedule	Ongoing project activity. Project forms are serving as primary data base.
XII. Conduct research study and follow-up	Schnall				Supervisors and workers from Bexar, Guadalupe, Comal, Kendall, and Bandera Counties and military child advocacy officers are participating.
A. Negotiate procedures for reporting sample case names	Schnall	9-15-76	10-5-76	Complete	
B. Obtain data systems support	Schnall	(9-20-76) 9-20-76	(2-28-77) 2-1-77	Complete	
C. Collect data	Schnall	(10-1-76) 10-1-76	(7-31-77) (8-31-77)	On Schedule	Inclusion of new cases in sample terminated 4-30-77. Coding being completed on all cases in study.
D. Analyze data	Schnall	(8-1-77) 7-25-77	(8-31-77) (10-15-77)	On Schedule	Preliminary analysis completed. More detailed analysis is continuing
E. Report data	Schnall	(9-1-77)	(9-30-77)		Preliminary results are included in annual report and will be presented at Military Family Research Conference in September.

OBJECTIVE	RESPONSIBLE INDIVIDUAL/ OFFICE	(SCHEDULED START) ACTUAL START	(SCHEDULED COMPLETION) ACTUAL COMPLETION	CURRENT STATUS	REMARKS
XIII. Project documentation and information dissemination	Grady, CARE Staff	12-30-75	(6-30-78)	On Schedule	Ongoing project activity. Numerous requests for information from public and private agencies have been received.
A. Curriculum Manual	Garcia	1-2-77	(12-31-77)	On Schedule	Final revisions and editing under way. CARE consultant to review manual and negotiate incorporation of curriculum into Academy of Health Sciences.
B. Second Annual Report	Marley, Project Staff	(7-15-77) 7-15-77	(9-2-77)	On Schedule	Report is being edited.
C. CAO Guide	Grady	5-25-77	Unscheduled		Format being conceptualized.
XIV. Conceptualize and conduct social policy study					
A. Determine study objectives and issue areas	Stern	3-15-77	(6-30-77) 6-30-77	Complete	Study objectives, anticipated benefits, work plan and schedule have been conceptualized.

OBJECTIVE	RESPONSIBLE INDIVIDUAL/ OFFICE	(SCHEDULED START) ACTUAL START	(SCHEDULED COMPLETION) ACTUAL COMPLETION	CURRENT STATUS	REMARKS
B. Examine child advocacy in San Antonio, including Project CARE innovations	Stern	(5-1-77) 5-1-77	(6-30-77) 6-30-77	Complete	Meetings have been held with representatives of DPW State/Regional Office, Office of the Surgeon General, and National Center on Child Abuse and Neglect to review and comment on study design.
C. Survey State, Federal, and military personnel	Stern	(6-1-77) 6-1-77	(9-30-77) (10-31-77)	On Schedule	Survey instruments pretested in August with DPW protective services staff and military Child Protection Council members.
D. Prepare report and recommendations	Stern	(10-1-77) (11-1-77)	(1-31-78)		Policy recommendations will be made to Office of the Surgeon General, DPW, and NCCAN. Working guidelines will be developed for child protection personnel.
XV. Identify and implement funding and staffing alternatives to ensure continuation of Project's mission and services	Marley	2-1-77	(6-30-78)	On Schedule	Conference with Air Force manpower projection personnel held 4-6-77. Preliminary staffing request submitted by WHMC CAO.


Objectives, Subobjectives, Tasks
1975
1976
1977
1978
J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J
(Planning Period)
I. Obtain and train staff; develop management and information procedures.
II. Gather necessary data for implementation of project objectives.
III. Develop strategies for implementation of project objectives

Project CARE Gantt Chart


Objectives, Subobjectives, Tasks
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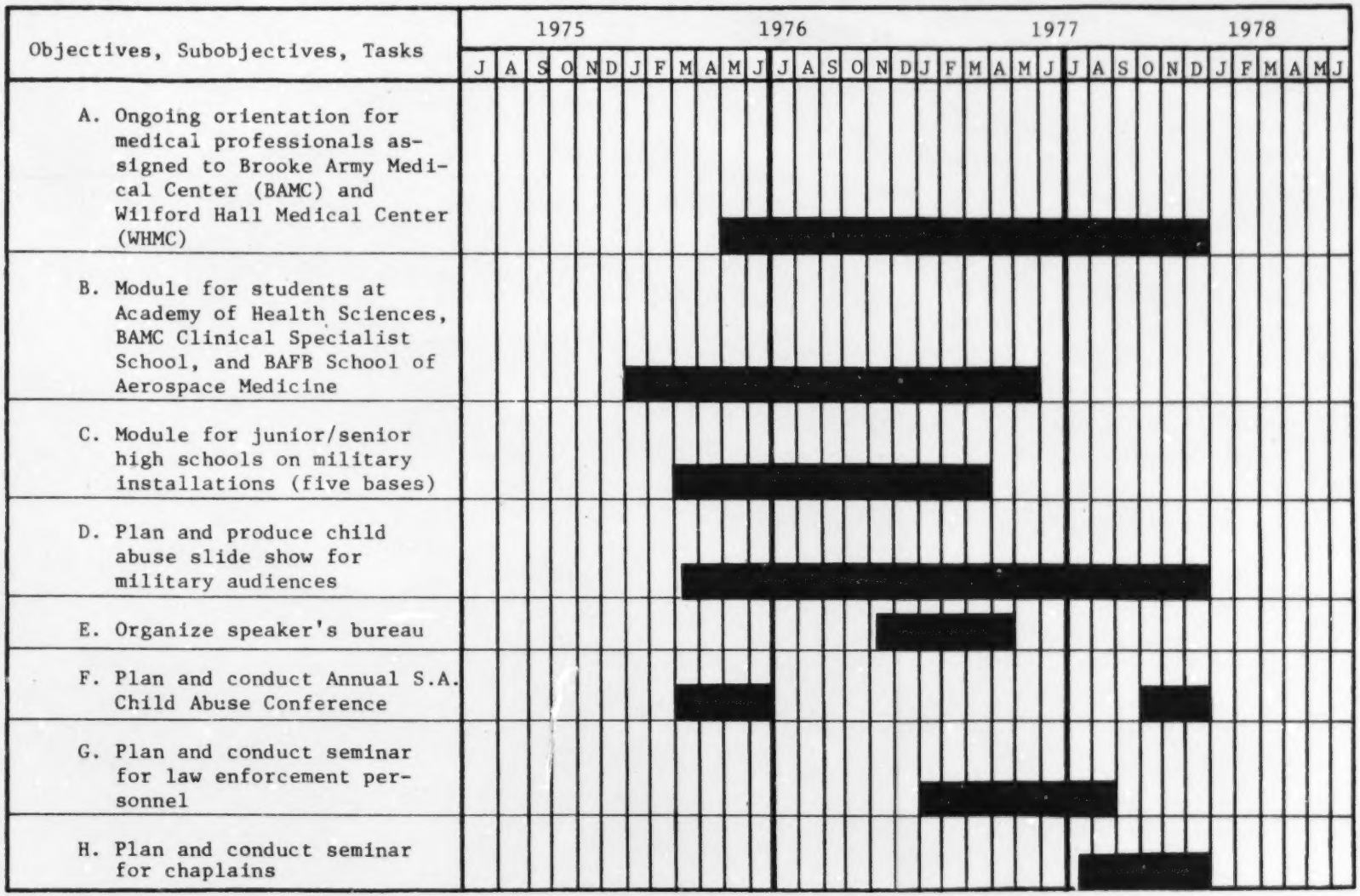
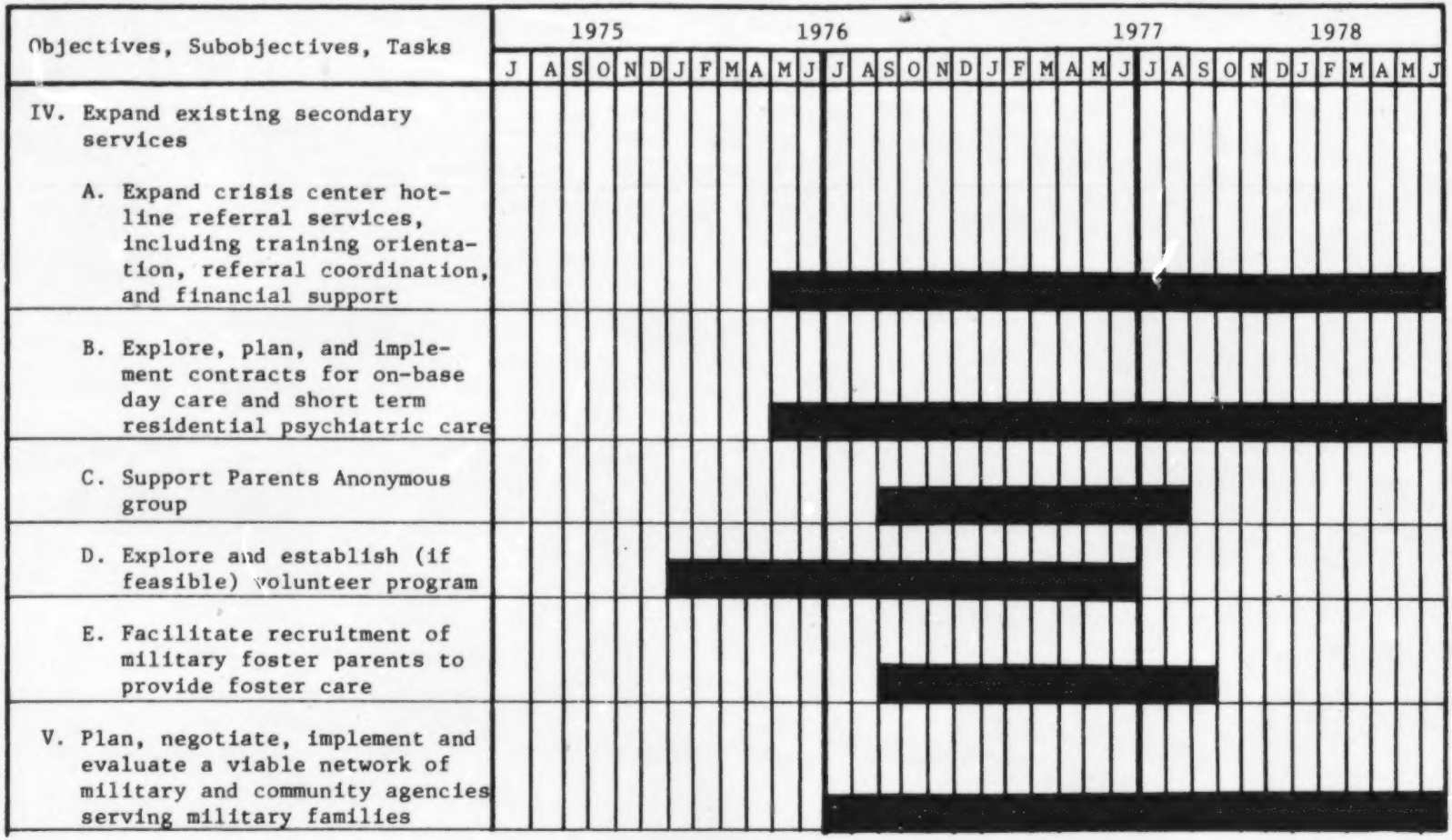
1976
1977
1978
J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J
(Implementation Period)
I. Acquaint all military families with available resources
A. Disseminate existing posters, advertisements, and pamphlets on five installations
B. Produce new pamphlets, posters, etc., for military audience
C. Disseminate specially produced posters and pamphlets on five installations
II. Produce, disseminate and update resource handbook to professionals in community and military
III. Plan and implement modules to educate professionals in identifying and helping troubled military families

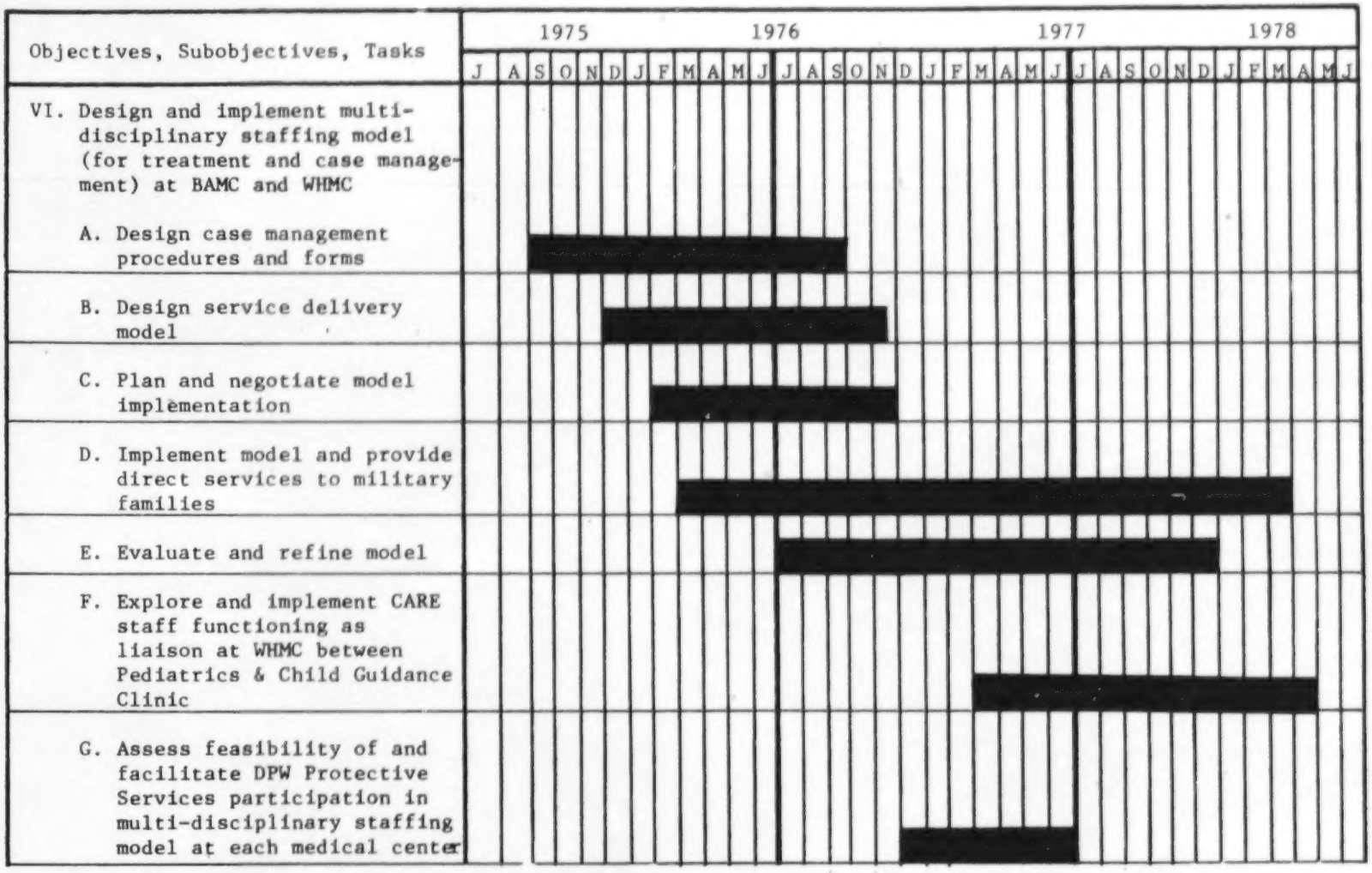
Project CARE Gantt Chart--Continued


Objectives, Subobjectives, Tasks
1975
1976
1977
1978
J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J
A. Ongoing orientation for medical professionals assigned to Brooke Army Medical Center (BAMC) and Wilford Hall Medical Center (WHMC)
B. Module for students at Academy of Health Sciences, BAMC Clinical Specialist School, and BAFB School of Aerospace Medicine
C. Module for junior/senior high schools on military installations (five bases)
D. Plan and produce child abuse slide show for military audiences
E. Organize speaker's bureau
F. Plan and conduct Annual S.A. Child Abuse Conference
G. Plan and conduct seminar for law enforcement personnel
H. Plan and conduct seminar for chaplains

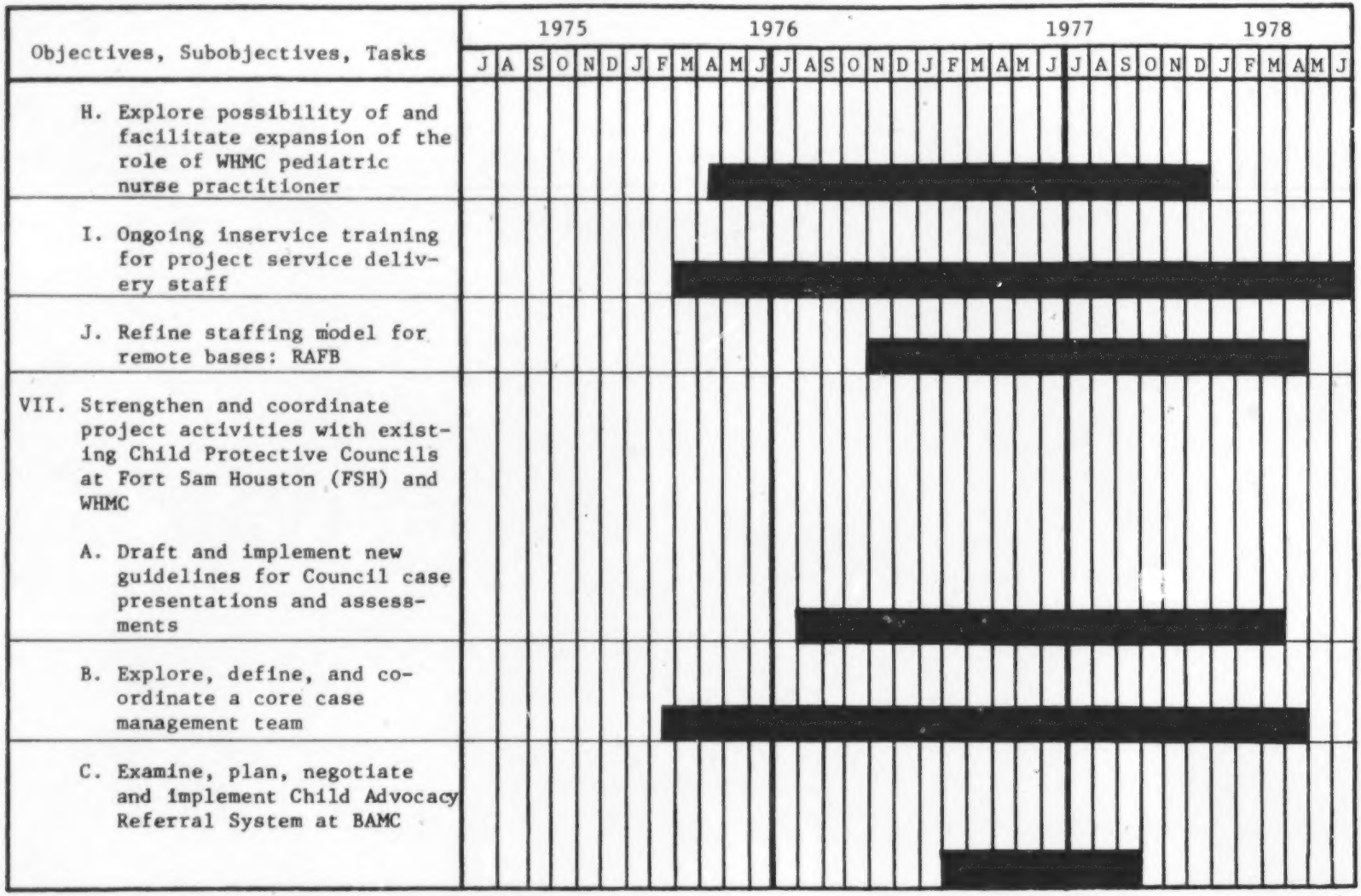
Project CARE Gantt Chart--Continued


Objectives, Subobjectives, Tasks
1975
1976
1977
1978
J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J
IV. Expand existing secondary services
A. Expand crisis center hot-line referral services, including training orientation, referral coordination, and financial support
B. Explore, plan, and implement contracts for on-base day care and short term residential psychiatric care
C. Support Parents Anonymous group
D. Explore and establish (if feasible) volunteer program
E. Facilitate recruitment of military foster parents to provide foster care
V. Plan, negotiate, implement and evaluate a viable network of military and community agencies serving military families

Project CARE Gantt Chart--Continued


Objectives, Subobjectives, Tasks
1975
1976
1977
1978
J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J
VI. Design and implement multi-disciplinary staffing model (for treatment and case management) at BAMC and WHMC
A. Design case management procedures and forms
B. Design service delivery model
C. Plan and negotiate model implementation
D. Implement model and provide direct services to military families
E. Evaluate and refine model
F. Explore and implement CARE staff functioning as liaison at WHMC between Pediatrics & Child Guidance Clinic
G. Assess feasibility of and facilitate DPW Protective Services participation in multi-disciplinary staffing model at each medical center

Project CARE Gantt Chart--Continued


Objectives, Subobjectives, Tasks
1975
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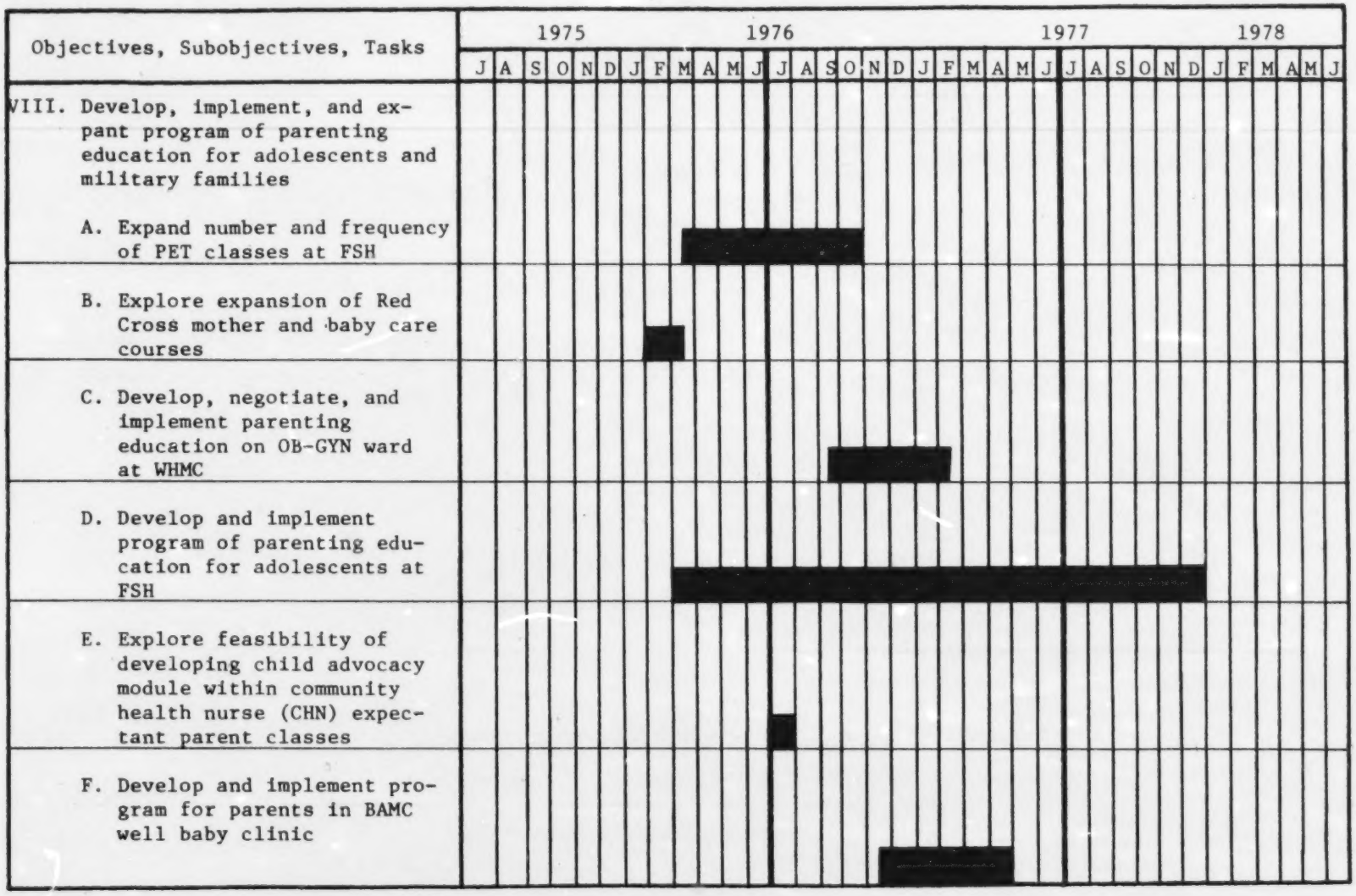
J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J
H. Explore possibility of and facilitate expansion of the role of WHMC pediatric nurse practitioner
I. Ongoing inservice training for project service delivery staff
J. Refine staffing model for remote bases: RAFB
VII. Strengthen and coordinate project activities with existing Child Protective Councils at Fort Sam Houston (FSH) and WHMC
A. Draft and implement new guidelines for Council case presentations and assessments
B. Explore, define, and coordinate a core case management team
C. Examine, plan, negotiate and implement Child Advocacy Referral System at BAMC

Project CARE Gantt Chart--Continued


Objectives, Subobjectives, Tasks
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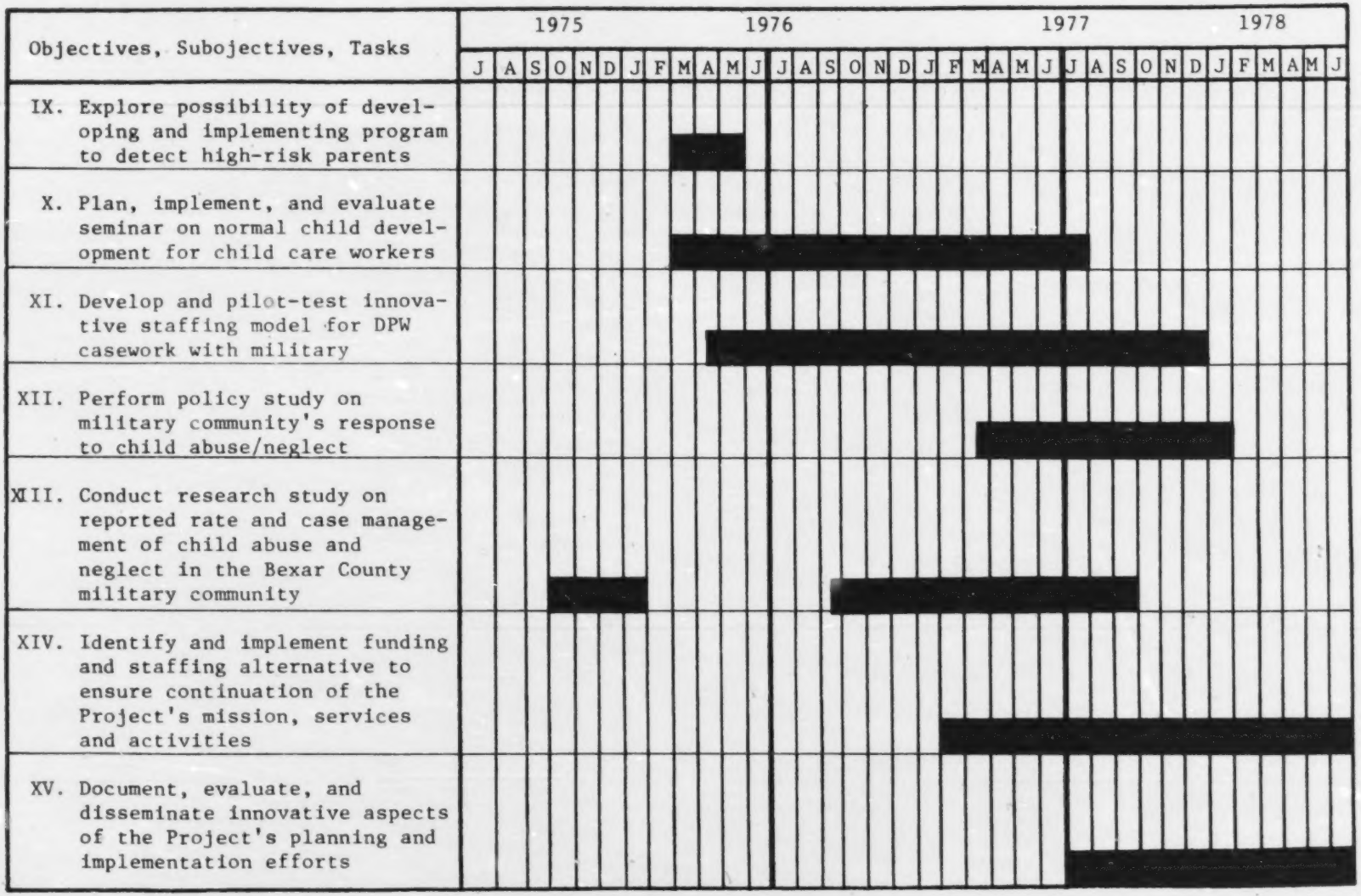
J A S O N D J F M A M J J A S O N D J F M A M J J A S O N D J F M A M J
VIII. Develop, implement, and expant program of parenting education for adolescents and military families
A. Expand number and frequency of PET classes at FSH
B. Explore expansion of Red Cross mother and baby care courses
C. Develop, negotiate, and implement parenting education on OB-GYN ward at WHMC
D. Develop and implement program of parenting education for adolescents at FSH
E. Explore feasibility of developing child advocacy module within community health nurse (CHN) expectant parent classes
F. Develop and implement program for parents in BAMC well baby clinic

Project CARE Gantt Chart--Continued


Objectives, Subojectives, Tasks
1975
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IX. Explore possibility of developing and implementing program to detect high-risk parents
X. Plan, implement, and evaluate seminar on normal child development for child care workers
XI. Develop and pilot-test innovative staffing model for DPW casework with military
XII. Perform policy study on military community's response to child abuse/neglect
XIII. Conduct research study on reported rate and case management of child abuse and neglect in the Bexar County military community
XIV. Identify and implement funding and staffing alternative to ensure continuation of the Project's mission, services and activities
XV. Document, evaluate, and disseminate innovative aspects of the Project's planning and implementation efforts

Project CARE Gantt Chart--Continued

Section 9

PROJECT DOCUMENTATION AND DISSEMINATION

Project documentation is on schedule. Concerned agencies and individuals have been kept informed of the project's status through the monthly distribution of tracking charts and weekly status reports. In addition, wide dissemination has been made of reports on the project's progress. An executive summary of the 1976 annual report has proved useful in informing military and community decision makers of CARE's progress.

Production and dissemination of project information and educational materials has been targeted at the specific audiences necessary to CARE's mission. One major effort was the project's seminar for military and civilian law enforcement officers. The seminar, held on 24 June 1977, brought together influential members of most of the major law enforcement, legal, and social agencies that deal with child abuse and neglect in the San Antonio area. These agency leaders were exposed to the latest techniques for dealing with the CA/N problem and went away with a better understanding of the proper functioning of their own and each other's agencies.

Full distribution of an updated revision of the Project CARE Resource Guidebook was completed this year. In addition to the military distribution, wide dissemination of the guidebook was made to local school districts and social work educators, government, social, health, and law enforcement agencies. Agencies that requested large numbers of copies for internal distribution included the Bexar County Mental Health and Mental Retardation Commission; the Texas Rehabilitation Commission; and the Northeast Independent School District (NEISD), for distribution to the counselors in its schools in areas with heavy concentrations of military families. NEISD has also requested, and received, permission to reproduce information from the guidebook.

The Project CARE media campaign has been directed at publicizing individual segments of its program. To this end stories publicizing such items as the need for military foster families and the OB-GYN Ward parenting classes were released, primarily to military community publications. Release to major area daily newspapers was made on stories such as the Law Enforcement Seminar.

Two bulletin board size posters were designed and printed locally by the project. One poster solicited CA/N reports and the other advertized CARE services. Copies of each were customized for use on each of the local military installations, and were distributed through the Child Advocacy Officers (CAOs). These posters have also been reproduced as advertisements in installation newspapers. A general information pamphlet on CARE was also produced locally, as was mail out and distribution material for the law enforcement seminar. Texas State Department of Public Welfare printed material has also been distributed, after overprinting with Project CARE information.

Presentations by the CARE staff have served to educate many groups and have publicized the activities of Project CARE. These presentations have been made to military and civilian audiences, not only in the San Antonio area but also to professionals in many other parts of the country. Many of these lesson plans have been compiled into a curriculum manual for CA/N presentations that will contain sample material for all audience levels.

A large volume of mail inquiries have required detailed responses. CARE staff has responded to requests for information and assistance from social work agencies in more than a dozen states and military child advocacy personnel in all four of the military branches. Extensive information has also been furnished for almost a dozen professional schools at major universities. These include state supported universities in Michigan, Wisconsin, Iowa, South Carolina, Oregon, North Dakota, California, Texas, and Alabama.

Primary subjects of the inquiries from the social agencies was the CARE service delivery program, prevention/education, and civilian agency interface arrangements with the military. The military CA/N personnel required detailed information on the organization of an effective CA/N and Advocacy program. The university inquiries generally solicited overall information on the project's activities and CA/N incidence data.

Third year plans call for revising, updating, and reprinting the resource guidebook; editing, refining, and printing the curriculum manual; and developing, printing, and publishing a guide for military CA/N and advocacy personnel.

Negotiations have begun with the Army motion picture activity housed on Fort Sam Houston for the production of a 16mm motion picture on military CA/N procedures. This film is to replace the slide/sound show originally planned since it has been determined that the medium of motion pictures has largely replaced the use of slides in the Armed Forces.

The following tentative plot outline was conceptualized as a possible method of presentation of material that could deliver the message of the need for reporting and treating child abuse and neglect and also show the recommended handling procedures for dealing with child abuse and neglect within the military setting. The story would be told by following two families with child abuse and neglect problems.

The whole spectrum of resources available to these families can be covered as they move into and through the existing systems at two Air Force bases. The families both begin at Randolph Air Force Base. Family #1 is involved in neglect of their young child. This can be shown as repeated incidents (child alone in car at commissary, left unsupervised at play near traffic etc.) This can culminate with the parents going on the town and the child becoming ill while in the care of a young and inexperienced baby sitter. This leads to a child neglect report at the medical facility. This case can be resolved by the base child advocacy officer with the use of local resources (PET training, family and budgeting counseling, etc.)

Family #2 lives off base and is involved in a child abuse case with serious injury to the child. The child is hospitalized at WHMC and the CA/N case is referred because of the more extensive need for services. This case can show the interaction of the military and BCCW in a case with non-military involvement. The treatment of the mother for mental health problems and the fatehr for alcoholism can be shown and the use of foster care facilities of DPW can be explained. The nonpunative handling of the case can be stressed and the team treatment concepts can be demonstrated.

A new media campaign to publicize the CARE services is planned and releases of journal articles to disseminate the findings resulting from CARE's research study, policy study, service delivery innovation and experience in military/civilian CA/N interface. The third and final Project CARE Annual Report is scheduled for completion April-June 1978.

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